



Sequential Intercept Mapping Report – Milwaukee County, WI

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Acknowledgement

The GAINS Center wishes to thank the Milwaukee Community Justice Council and the Milwaukee District Attorney's Office for the assistance with the coordination of this event.

Introduction:

The Milwaukee Community Justice Council contracted with Policy Research Associates (PRA) to develop behavioral health and criminal justice system maps focusing on the existing connections between behavioral health and criminal justice programs to identify resources, gaps and priorities in Milwaukee County.

Background:

The *Sequential Intercept Mapping workshop* has three primary objectives:

1. Development of a comprehensive picture of how people with mental illness and co-occurring disorders flow through the criminal justice system along five distinct intercept points: Law Enforcement and Emergency Services, Initial Detention and Initial Court Hearings, Jails and Courts, Re-entry, and Community Corrections/Community Support.
2. Identification of gaps, resources, and opportunities at each intercept for individuals in the target population.
3. Development of priorities for activities designed to improve system and service level responses for individuals in the target population.

The participants in the workshops represented multiple stakeholder systems including mental health, substance abuse treatment, health care, human services, corrections, advocates, individuals, law enforcement, health care (emergency department and inpatient acute psychiatric care), and the courts. Travis Parker, M.S., L.I.M.H.P., C.P.C and Connie Milligan, L.C.S.W., for SAMHSA's GAINS Center for Behavioral Health and Justice Transformation and Policy Research Associates, Inc., facilitated the workshop session.

Thirty-four (34) people were recorded present at the Milwaukee County SIM.

Milwaukee County, WI SIM Agenda
Day 1: June 24, 2015

8:30 Registration and Networking

9:00 Openings

- Welcome and Introductions
- Overview of the Workshop
- Workshop Focus, Goals, and Tasks
- Collaboration: What's Happening Locally

What Works!

- Keys to Success

The Sequential Intercept Model

- The Basis of Cross-Systems Mapping
- Five Key Points for Interception

Cross-Systems Mapping

- Creating a Local Map
- Examining the Gaps and Opportunities

Establishing Priorities

- Identify Potential, Promising Areas for Modification Within the Existing System
- Top Five List
- Collaborating for Progress

Wrap Up

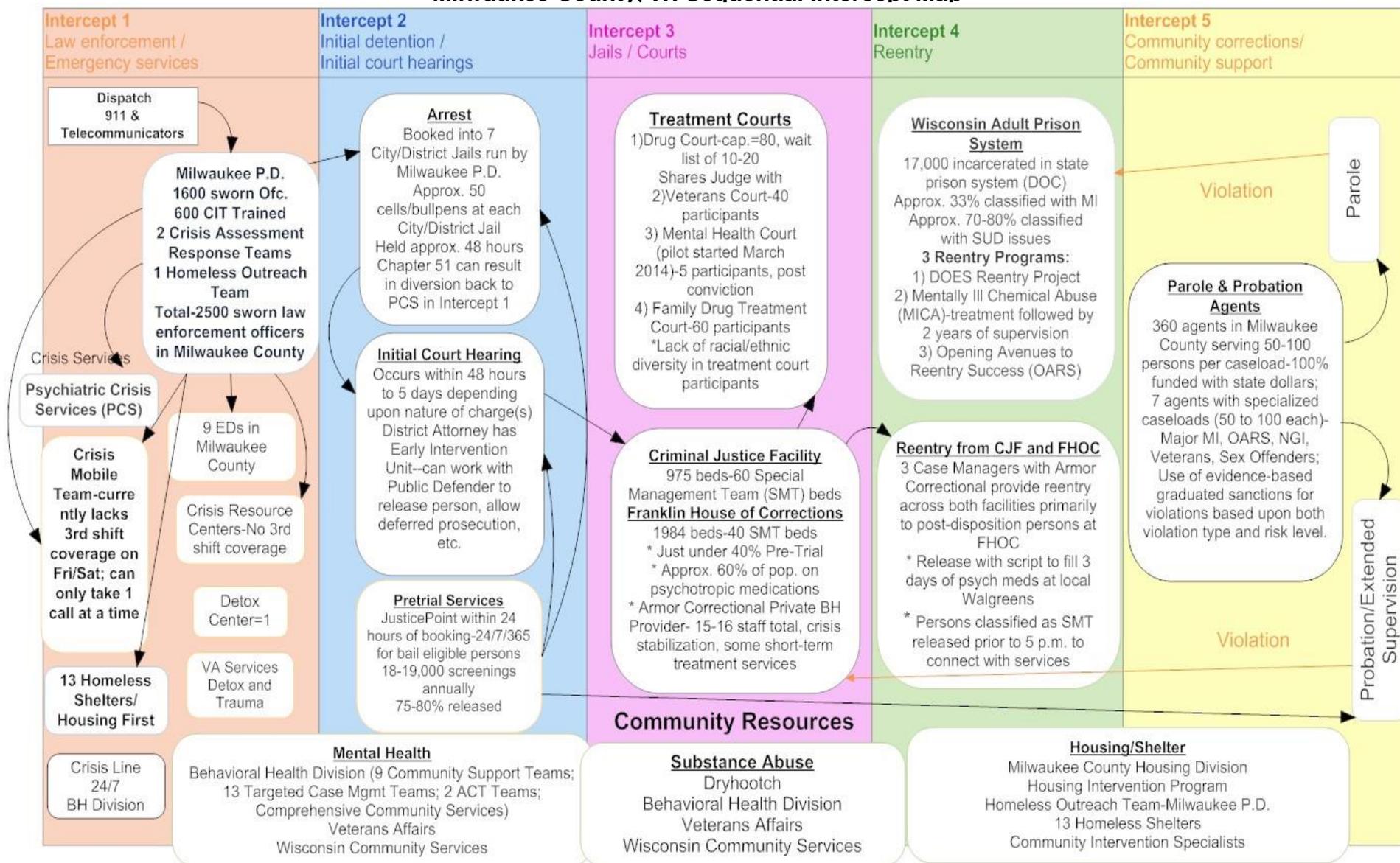
- Review
- Setting the Stage for Day 2

4:30 Adjourn

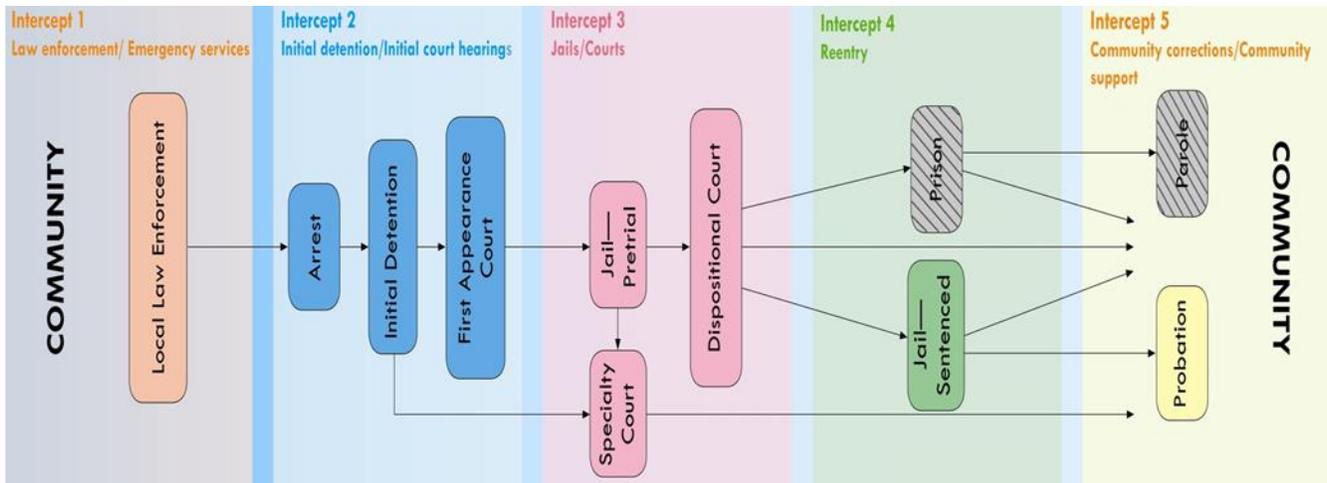
Milwaukee County, WI SIM Agenda
Day 2: June 25, 2015

- 8:30** **Registration and Networking**
- 9:00** **Opening**
- Preview of the Day
- Review**
- Day 1 Accomplishments
 - Local County Priorities
 - Keys to Success in Community
- Action Planning**
- Identify Objectives and Action Steps for top priorities
 - Determine who or what committees will be responsible
 - Identify timelines
- Finalizing the Action Plan**
- Share Action Plan with the group
- Next Steps**
- Summary and Closing**
- 12:30** **Adjourn**

Milwaukee County, WI Sequential Intercept Map



Intercept 1



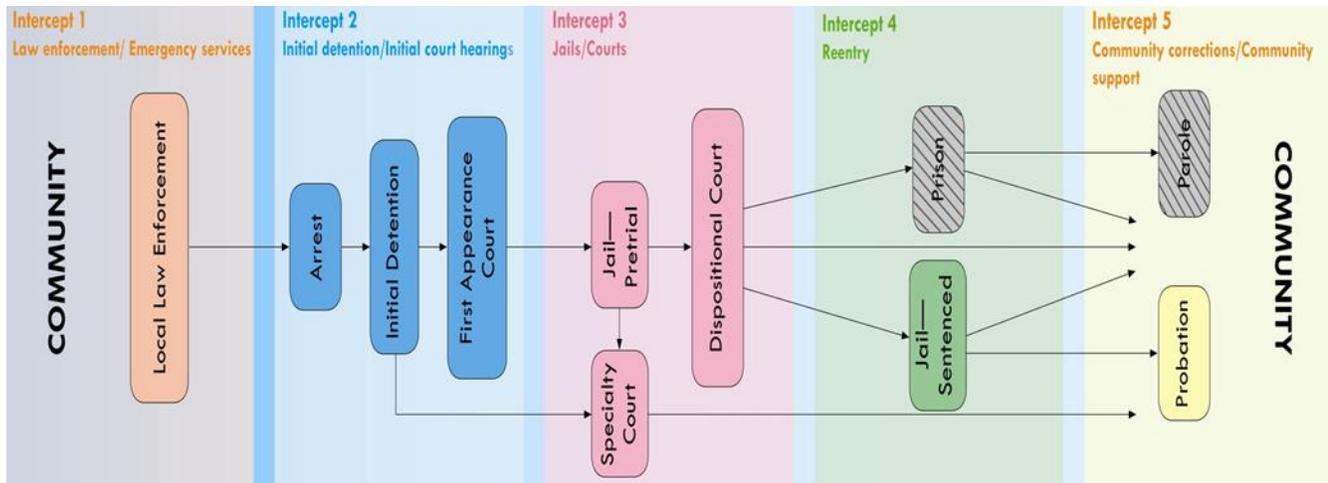
Resources

- The Milwaukee Police Department has two Crisis Assessment Response Teams (CART) and a Homeless Outreach Team (see gap below)
- Housing Intervention would like to be involved in diversion by meeting immediate housing needs
- Housing First
- The VA Police and the Milwaukee Police Department are coordinating around detox treatment, etc.
- Crisis Mobile Team for adults (5 weekdays, 24 hours/day and 17 hours/day on weekends)
- There are 13 shelters in Milwaukee County
- There are 9 emergency departments (ED) in Milwaukee County
- There is an emergency department to medical home program to connect people to upon ED discharge
- A statewide Health Information Exchange exists
- There is one detox facility in Milwaukee County

Gaps

- Dispatch personnel are not Crisis Intervention Team (CIT) trained
- Most Telecommunicators are not CIT trained (some receive training, but the turnover rate is high)
- The Milwaukee Police Department cannot go outside the city limit and their CART teams cannot meet the demand. The Sheriff's Office needs a Crisis Assessment Response Team and a Homeless Outreach Team as well (see resource above)
- Crisis Resource Centers can help the third shift officers by providing diversion; however, they are not open during the third shift and refuse people
 - Lack of diversion resources after hours
- The Crisis Mobile Team lacks Friday/Saturday third shift coverage
- There is a large gap in data- a lack of information sharing/availability to see if an individual is already under commitment
- If there was an increase in CART teams and third shift coverage at Crisis Resource Centers, then the District Attorney's Office could aid in more Intercept 1 diversion
- People with behavioral health disorders receiving city level citations have a high Failure To Appear rate in court
- There is a need for forensic peer support workers at Intercept 1
- The shelters do not have options for this population 24 hours/day. They operate under certain business hours.
- Officers have to call 211, not the shelters, to find about bed space- via Coordinated Entry
- There is not enough medical health home capacity
- There is a need to bring CART, the Homeless Outreach Team, and Psychiatric Crisis Services (PCS) to scale in order to meet the County's demands
- The Hospital Emergency Department physicians will tell law enforcement to go to PCS instead of the hospital
- There is a gap in dialogue between partners about how to best use PCS, the Hospital Emergency Departments, and other available crisis services

Intercepts 2 & 3



Resources

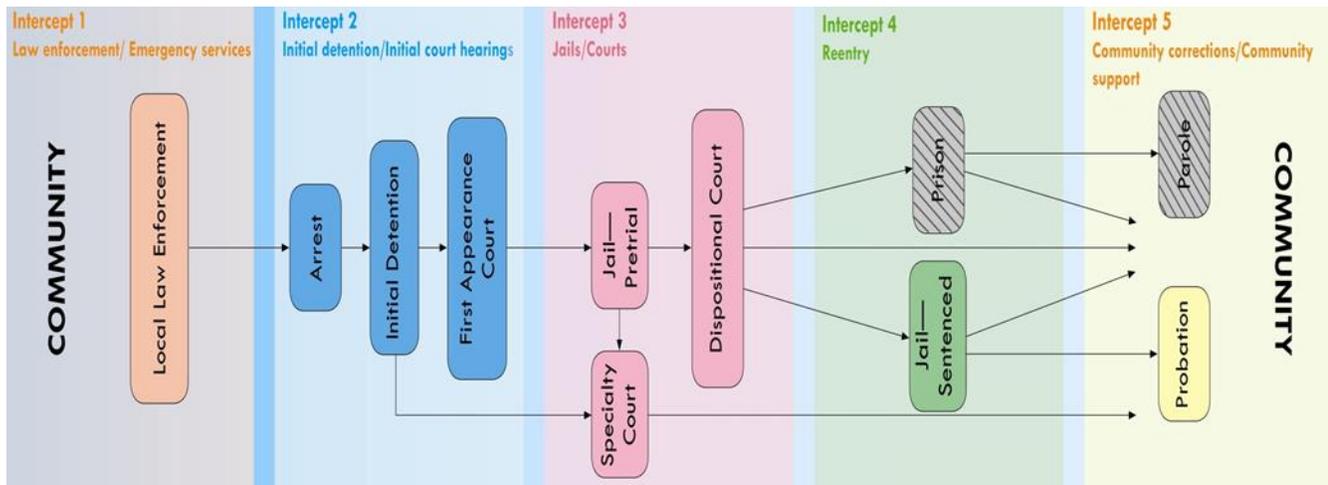
- The CART team calls information into the jail before arriving- Armor Health
- Individuals are booked into City Jail (50 cells/bullpens over 7 districts) and then transported to County Jail
- Chapter 51 can result in diversion
- Justicepoint pretrial screening (24/7/365) for anyone eligible for bail, within 24 hours of booking
- The District Attorney’s Office can work with the Police Department to release a person and do deferred prosecution
- Armor Correctional conducts screening and assessment, and has a mental health unit (19 beds)
- Correctional officers have received CIT training
- The jail runs daily lists for veterans and sends the information to the VA
- Peer support services are Medicaid reimbursable

Gaps

- There is a lack of data available to Justicepoint and the District Attorney’s Office to identify people with behavioral health disorders for pretrial diversion
- If Housing Intervention can receive the information from the district/city jail about persons who are homeless, they could potentially divert individuals
- Questions about developmental disabilities or brain injury are not being asked at booking

- There is a lack of peer support within Intercept 2
- People discharged from PCS are only given paper referral information to services
- There is a shortage of Medicaid providers/prescribers- the wait can be months long
- Pre-trial doesn't receive behavioral health information in a timely manner in order to make a diversion decision. Many of these people cannot afford bail
- Managed care entities need to come to the table (or even be asked to the table)
- There needs to be a greater effort to identify people before they become "heavy utilizers"
- Medication formularies switch often due to cost
- It can be difficult for jail staff to communicate with community service providers
- There is a lack of peer support involvement at the jail
- Inmates/persons classified as "high risk" at one time continue to be classified as such in subsequent bookings
- The Drug Treatment Court has a waiting list of 10-20 people currently
- The Drug Treatment Court is primarily servicing Caucasians, which does not reflect the diversity of the community
- Housing is an issue for Drug and Family Treatment Court participants
- There is a need for expanded peer support services, such as peers who can be paid members of the treatment teams

Intercepts 4 & 5



Resources

- There is prerelease planning 6 months prior to release
- Three Case Managers work at the House of Corrections
- Some of the probation/parole agents have degrees in mental health fields and/or on-the-job training concerning this population

Gaps

- The Wisconsin Secure Prison Facility can offer good treatment for mental illness, but often requires competency to be raised by an attorney to move individuals to a hospital
- There is a housing issue as they cannot discharge to shelter/homelessness
- There is no peer support in Intercept 4
- Chapter 51- go to prison instead of overcrowded hospital
- Sex offenders are being released without housing
- Wisconsin is a Medicaid termination state
- There is disconnect between the prison and probation/parole
- Burn out of prison staff
- High caseloads

- There used to be 10 mental health parole agents, but there are now only 7 due to funding cuts
- Some agents have 50-100 people on a caseload
- The sex offender caseload is handled by 3 special agents
- There are 3.5 FTE psychiatrists for 13,000 individuals in the community
- There is limited specialty training for parole
- Graduated sanctions were just initiated (1-90 days)
- An ACT Team was just formed
- There is a lack of peer support in Intercept 5
- The list of providers is ever-changing, with a full waiting list
- There is one telehealth physician (through Horizon) for parole
- There is no required appointment at release
- There are a percentage of individuals with Severe Mental Illness who refuse medication services
- The House of Correction is difficult to reenter if there is no previous service or short stay
- Those discharged are not given medication, but are given a prescription card to Walgreens for 7 days of medications. There are two locations where they can receive this:
 - HOC Walgreens: 9527 S. 27th St.
 - CJF Walgreens: 3522 W. Wisconsin Avenue
- Appointments are not made before the medications run out
- There is a need for data/literature that demonstrates that good reentry planning contributes to a reduction in recidivism (see Appendix 6 for resources)
- Support for family members of the affected individuals is lacking

Priorities for Change as Determined by Mapping Participants

- Share data across criminal justice and behavioral health partners; include HIPAA analysis in this process. (15 votes)
- Expand Crisis Resource Center services to include coverage for 3rd shift. (14 votes)
- Expand Milwaukee Police Department CART team services to provide county wide services. (12 votes)
- Provide more Peer Support services across all intercepts with funding for their services. (9 votes)
- Create Intercept 2 diversion opportunities (5 votes)
- Increase capacity of Specialty Courts in Intercept 3. (4 votes)
- Increase psychiatric availability and capacity expansion through workforce development (3 votes)
- Provide more than 3 days of psychotropic medication at reentry (2 votes)
- Strengthen Pretrial and Reentry behavioral health services surrounding trauma (2 votes)
- Expand supported employment services (2 votes)
- Create a Reentry Council (2 votes)
- Give priority access to behavioral health services for persons with behavioral health and criminal justice involvement (1 vote)
- Offer immediate availability of Community Intervention Specialist for housing (1 vote)
- Provide screening for Intellectual and Development Disabilities (1 vote)
- PCS privatization will require coordination and communication among behavioral health and criminal justice partners. about transitioning
- Expand Assertive Community Treatment Teams
- Build community support and buy in for these efforts
- Increase the number of parole and probation agents with specialized caseloads

SIM Day 2 Dialogue

The day two, (half day) SIM training opened with a review of the SIM map created during day one. The discussion concerning the resources and gaps in services in Milwaukee County for people who are justice involved referenced a comment made during day one of the SIM that Milwaukee services are provided primarily by Caucasians who serve predominantly people of color. This generated an extensive dialogue about additional gaps in services on day two.

The discussion was considered to be of such value that the traditional “Priorities for Change” Action Planning was tabled. It was determined that the top five priorities proposed on day one (see list below) were currently being addressed and would continue to be addressed in upcoming Criminal Justice Planning committee meetings.

Below is a list of the additional gaps that were discussed during the day two Action Planning. Following them are additional resources that were discussed and that can be incorporated into new “Priorities for Change,” also listed below. The GAINS Center consultants’ recommendations in this document also include suggested strategies for addressing these gaps.

ADDITIONAL GAPS IN SERVICES- Day 2

- Trauma training is lacking for service providers in all Intercepts.
- There is a lack of cultural sensitivity toward justice involved people who are predominantly of color (African American and Hispanic) with predominantly Caucasian mental health, probation and parole service providers.
- Milwaukee is one of the most racially and ethnically divided cities in the nation. Peer Support Specialists of color are very much needed.
- The cultural insensitivity creates a toxic environment that re-traumatizes people involved in the justice system. The comment “every contact with justice is an opportunity to do harm” captures the spirit of the dialogue.
- High caseloads and limited training create burnout and inadequate time to “do the right thing.” This fosters an attitudinal indifference by service providers toward justice involved people.
- Services providers in mental health case management, probation and parole can be too quick to call the police when a person is in crisis. This reportedly occurs if the providers witness a behavior they disagree with, even something as minor as a dirty home. This creates a lack of trust between the providers and individuals in crisis. The service provider is often seen as an “officer” rather than someone who is representing the individuals’ best interests.
- The lack of trust toward service providers and the assumption that there is a negative attitude toward justice involved people affects how the individuals proceed through the justice system.
- It was reported that security staff in the hospital (Psychiatric Crisis Services-PCS) and bailiffs, who are persons of color, are being called to help communicate expectations in a way that can be understood. This has been helpful and speaks to the need for peer support and service personnel of color.
- Attitudes and actions of “coercion” are commonly used and are not helpful. Sensitivity training is needed across the Intercepts.

- The service system often demonstrates the view of “treatment-resistant clients” instead of exploring how the systems may have created “client-resistant services.”
- The Milwaukee County Police Department is entrusted with initiating the Chapter 51 civil commitment process. This can be traumatizing because some law enforcement are not approaching people with a sensitivity toward mental illness. Attempts to change the law to include others filing a Chapter 51 petition have not been successfully heard by the legislature in the last seven years of discussion.
- Violations of CSP conditional releases are sky rocketing. Recidivism has increased from 1-2 persons per week to 3-4 persons per day. This may be related to staff training and attitudinal problems.
- There is some concern that if a person has a “police hold,” Psychiatric Crisis Services (PCS) is directing them to the jail instead of to treatment.
- People without insurance have easier access to care than people with Medicaid coverage.
- The Crisis Assessment Response Teams (CART) are required to wear full TACT (SWAT Team) equipment including bullet proof vests, helmets and guns. This is not conducive to a trauma-informed intervention. In fact, it often re-traumatizes people. The question was asked, “Do we really want more of this?”
- The Sheriff’s Department was not involved in the mapping. While Detention Center staff may be professional, there are attitudinal problems at the top of the organization that foster negative attitudes toward justice involved people with behavioral health issues.

ADDITIONAL RESOURCES- Day 2

- There is a structure in place to carry the work of this group forward through the Criminal Justice Mental Health Task Force. People are motivated to seek change and are looking outside the system.
- The “Safety and Justice Challenge” McArthur Foundation grant is an impetus to look for new solutions.
- Milwaukee has exceptional resources within its three major health care services (hospitals and university). There are many forward-thinking professionals who would be willing to help with research and service development. These groups need to be included in the planning and implementation processes moving forward.
- The city is working hard to develop an early intervention model. It matches interventions to criminogenic risk factors. It was noted that trauma factors need to be added into the equation.
- Prison provides a two week supply of medication at release and offers tele-psychiatry services.

PRIORITIES FOR CHANGE- Day 2

- A “trauma-informed” system of care needs to be developed at every Intercept. Training is needed for all personnel involved.
- Screening tools for trauma need to be included in the intake process at each Intercept.
- A system needs to be created that fosters the “right choices” for people that are being served with behavioral health disorders.
- Sensitivity training related to cultural differences needs to be developed and delivered.

- Training needs to be on-going to address staff turnover. This includes training for CIT, trauma and cultural sensitivity.
- Explore “Intercept Zero” crisis services/resources so they can be included in the development of intervention within the “Priorities for Change.”

Recommendations

The following recommendations are made for your consideration to emphasize their importance:

1. **Provide data matching:** Creating a data match with information from local/state resources from time of arrest to Pre-Trial can enhance diversion opportunities before and during the arraignment process. See below resources on Data Analysis/Matching and Information Sharing.
2. **Expand peer support across the Intercepts:** Peer support is particularly helpful in easing the traumatization of the corrections process and encouraging consumers to engage in treatment services. Settings that have successfully integrated peers include crisis evaluation centers, emergency rooms, jails, treatment courts, and reentry services. It is the understanding of the GAINS Center staff that Wisconsin has a Certified Peer Specialist program and the SAMSHA-funded Grassroots Empowerment center provides training. GAINS staff recommends utilizing these services and also offers GAINS Center Senior Project Associate LaVerne Miller as a resource for more assistance. Her contact information is below. See below resources on Peer Support for more information.

LaVerne D. Miller, Esq.
Policy Research Associates, Inc.
345 Delaware Avenue
Delmar, NY 12054
(518) 439-7415 x 5245
LMiller@prainc.com

3. **Increase trauma training for justice involved personnel:** Trauma training that specifically targets personnel involved in criminal justice addresses the unique issues related to traumatization and its impact on recidivism. This may be helpful in changing cultural attitudes and lead to increased diversion efforts. One example discussed on Day 2 of the SIM is the *How Being Trauma-Informed Improves Criminal Justice System Responses* training available through SAMHSA's GAINS Center (see http://gainscenter.samhsa.gov/trauma/trauma_training.asp). Also see below resources on Trauma-Informed Care.
4. **Expand scope of Crisis Intervention Team (CIT) officers/alter CART teams:** Milwaukee County's third priority (see above) is the expansion of the CART team to provide countywide services. Staff of the GAINS Center recommend that the Milwaukee Police Department and the Milwaukee Sheriff's Office either expand the scope of CIT officers or alter the functioning of the CART teams to provide services without being suited in SWAT-team like gear, which can prove to be retraumatizing to individuals with behavioral health disorders.
5. **Expand Intercepts 2 and 3 diversion opportunities:** Diversion at pre-trial is currently being implemented and could be increased/expanded with more focused attention on making linkages to service options or structured diversion programs. Diversion in Intercept 2 could be expanded

through an expansion of information sharing between the Justicepoint and Housing Intervention programs. Intercept 3 treatment court diversion programs could be expanded through the inclusion of peer support. See below resources on Intercepts 2 and 3 diversion.

6. **Expand, coordinate and connect reentry services to community supervision:** Explore developing a Reentry Council or integrate current efforts into the work of the Mental Health Community Justice Council. Issues to address include fair housing, “ban the box,” and educating employers. See below resources on Reentry.

7. **Expand the definition of who can file a Chapter 51:** Reduce the reliance on law enforcement to initiate a Chapter 51 and give the responsibility to assess and file civil commitment papers as part of the overall goal to increase diversion to qualified mental health providers. Law enforcement professionals currently serve as the community screeners, which may increase the likelihood of the jail becoming a highly utilized portal for individuals who need treatment and are not accepted for services elsewhere. See below resources on Civil Commitment Procedures.

Resources

Civil Commitment Procedures

- Treatment Advocacy Center. *Mental Health Commitment Laws A Survey of the States*. <http://www.tacreports.org/storage/documents/2014-state-survey-abridged.pdf>

Competency Evaluation and Restoration

- SAMHSA's GAINS Center. *Quick Fixes for Effectively Dealing with Persons Found Incompetent to Stand Trial*. http://gainscenter.samhsa.gov/pdfs/integrating/QuickFixes_11_07.pdf
- Finkle, M., Kurth, R., Cadle, C., and Mullan, J. (2009) Competency Courts: A Creative Solution for Restoring Competency to the Competency Process. *Behavioral Science and the Law*, 27, 767-786. <http://onlinelibrary.wiley.com/doi/10.1002/bsl.890/abstract;jsessionid=5A8F5596BB486AC9A85FD FBEF9DA071D.f04t04>

Crisis Response and Law Enforcement

- International Association of Chiefs of Police. *Building Safer Communities: Improving Police Responses to Persons with Mental Illness*. <http://www.theiacp.org/portals/0/pdfs/ImprovingPoliceResponsetoPersonsWithMentalIllnessSummit.pdf>
- Saskatchewan Building Partnerships to Reduce Crime. *The Hub and COR Model*. <http://saskbprc.com/index.php/2014-08-25-20-54-50/the-hub-cor-model>
- Suicide Prevention Resource Center. *The Role of Law Enforcement Officers in Preventing Suicide*. <http://www.sprc.org/sites/sprc.org/files/LawEnforcement.pdf>
- Bureau of Justice Assistance. *Engaging Law Enforcement in Opioid Overdose Response: Frequently Asked Questions*. https://www.bjatrainng.org/sites/default/files/naloxone/Police%20OOD%20FAQ_0.pdf

Data Analysis/Matching

- Urban Institute. *Justice Reinvestment at the Local Level Planning and Implementation Guide*. <http://www.urban.org/publications/412233.html>

- The Council of State Governments Justice Center. *Ten-Step Guide to Transforming Probation Departments to Reduce Recidivism*. <http://csgjusticecenter.org/corrections/publications/ten-step-guide-to-transforming-probation-departments-to-reduce-recidivism/>
- New Orleans Health Department. *New Orleans Mental Health Dashboard*. <http://www.nola.gov/getattachment/Health/Data-and-Publications/NO-Behavioral-Health-Dashboard-4-05-15.pdf/>
- Pennsylvania Commission on Crime and Delinquency. *Criminal Justice Advisory Board Data Dashboards*. <http://www.pacjabdash.net/Home/tabid/1853/Default.aspx>
- Corporation for Supportive Housing. *Jail Data Link Frequent Users: A Data Matching Initiative in Illinois* (See Appendix 3)

Information Sharing

- American Probation and Parole Association. *Corrections and Reentry: Protected Health Information Privacy Framework for Information Sharing*. <http://www.appa-net.org/eweb/docs/APPA/pubs/CRPHIPFIS.pdf>

Intercepts 2 and 3 Diversion Examples

- A long standing pretrial Mental Health Diversion Court in Louisville, Kentucky is directed by Jim Birch, Seven County Services Justice Division (jburch@sevencounties.org; 502-589-88926). Their 2013 annual report includes the following data:
 - Population: diversion for people with SPMI and fewer than five prior convictions
 - Referred to intensive outpatient services with a minimum of one contact per week
 - Court reviewed every 6 months – over 1 to 2 years
 - No plea entered, charges dropped at completion
 - Graduating 10-15 per year, with a savings of \$217,000-\$406,000 per year
- There are several examples in Florida of post booking and pretrial release programs where the target population is individuals with serious mental illnesses. See the contact individuals below:

Alachua County
Leah Vail, Forensic Program Director
(352) 538-7429 leah.vail@MBHCL.org

Orange County
Laura Gailey, Director of Acute Care
(407) 875-3700 x 6622 Laura.Gailey@aspirehp.org

Miami- Dade County
Cindy Schwartz, Director, 11th Judicial Mental Health Project
(305) 213-5676 cschwartz@jud11.flcourts.org

Pinellas County
Bob Dillinger, Public Defender
(727) 464-6516

Mental Health First Aid

- Illinois General Assembly. *Public Act 098-0195: "Illinois Mental Health First Aid Training Act."*
<http://www.ilga.gov/legislation/publicacts/fulltext.asp?Name=098-0195>
- Mental Health First Aid. <http://www.mentalhealthfirstaid.org/cs/>
- Pennsylvania Mental Health and Justice Center of Excellence. *City of Philadelphia Mental Health First Aid Initiative.*
http://www.pacenterofexcellence.pitt.edu/documents/Session10_Piloting_the_Public_Safety_Versi_on_of_MHFA.ppt

Peer Support

- Involving Peers in Criminal Justice and Problem-Solving Collaboratives.
<http://gainscenter.samhsa.gov/cms-assets/documents/62304-42605.peersupportfactsweb.pdf>
- The Impact of Forensic Peer Support Specialists on Risk Reduction and Discharge Readiness in a Psychiatric Facility: A Five-Year Perspective.
http://www.psychosocial.com/IJPR_16/Impact_of_Forensic_Peer_Support_Raia.html
- Peer Support within Criminal Justice Settings: The Role of Forensic Peer Specialists.
http://gainscenter.samhsa.gov/peer_resources/pdfs/Davidson_Rowe_Peersupport.pdf
- Overcoming Legal Impediments to Hiring Forensic Peer Specialists.
http://gainscenter.samhsa.gov/peer_resources/pdfs/Miller_Massaró_Overcoming.pdf

Reentry

- SAMHSA's GAINS Center. *Guidelines for the Successful Transition of People with Behavioral Health Disorders from Jail and Prison.* <http://gainscenter.samhsa.gov/cms-assets/documents/147845-318300.guidelines-document.pdf>

- Community Oriented Correctional Health Services. *Technology and Continuity of Care: Connecting Justice and Health: Nine Case Studies* <http://www.cochs.org/files/HIT-paper/technology-continuity-care-nine-case-studies.pdf>
- Reentry/coordination of care legislation in Texas (Texas House Bill 1908). <http://openstates.org/tx/bills/84/HB1908/>
- The Council of State Government's National Reentry Resource Center. <http://csgjusticecenter.org/ic/category/reentry/nrrc/>
- BJA's Center for Program Evaluation and Performance Management. <https://www.bja.gov/evaluation/program-corrections/reentry-index.htm>
- The National Institute of Justice's Offender Reentry page. <http://www.nij.gov/topics/corrections/reentry/pages/welcome.aspx>
- To reduce recidivism, the Kentucky Department of Corrections mandated statewide reentry services with dedicated case managers, specialized probation and parole officers, along with regional reentry councils to organize local support services. See the below links for additional information.
<http://corrections.ky.gov/reentry/Pages/default.aspx>
http://www.kentuckyreentry.org/links_resources.html
- See additional resources in Appendix 6

Resources/Funding

- Justice Reinvestment at the Local Level Planning and Implementation Guide. <http://webarchive.urban.org/publications/412233.html>
- The Sustainability Curve. <http://gainscenter.samhsa.gov/cms-assets/documents/144667-141965.the-sustainability-curve.pdf>
- The Sustainability Checklist: Guidelines for Federal Grantees. <http://gainscenter.samhsa.gov/cms-assets/documents/190941-834517.sustainability-checklist-final.pdf>

Screening and Assessment

- SAMHSA's GAINS Center. *Screening and Assessment of Co-Occurring Disorders in the Justice System*. http://gainscenter.samhsa.gov/topical_resources/cooccurring.asp
- Steadman, H.J., Scott, J.E., Osher, F., Agnese, T.K., and Robbins, P.C. (2005). Validation of the Brief Jail Mental Health Screen. *Psychiatric Services*, 56, 816-822.
http://gainscenter.samhsa.gov/pdfs/jail_diversion/Psychiatric_Services_BJMHS.pdf

Sequential Intercept Model

- Munetz, M.R., and Griffin, P.A. (2006). Use of the Sequential Intercept Model as an Approach to Decriminalization of People with Serious Mental Illness. *Psychiatric Services*, 57, 544-549.
<http://ps.psychiatryonline.org/doi/10.1176/ps.2006.57.4.544>
- Griffin, P.A., Heilbrun, K., Mulvey, E.P., DeMatteo, D., and Schubert, C.A. (2015). *The Sequential Intercept Model and Criminal Justice*. New York: Oxford University Press.
<https://global.oup.com/academic/product/the-sequential-intercept-model-and-criminal-justice-9780199826759?cc=us&lang=en&>
- SAMHSA's GAINS Center. *Developing a Comprehensive Plan for Behavioral Health and Criminal Justice Collaboration: The Sequential Intercept Model*. <http://gainscenter.samhsa.gov/cms-assets/documents/145789-100379.bh-sim-brochure.pdf>

Trauma-Informed Care

- SAMHSA, SAMHSA's National Center on Trauma-Informed Care, and SAMHSA's GAINS Center. *Essential Components of Trauma Informed Judicial Practice*.
http://www.nasmhpd.org/docs/NCTIC/JudgesEssential_5%201%202013finaldraft.pdf
- SAMHSA's GAINS Center. *Trauma Specific Interventions for Justice Involved Individuals*.
<http://gainscenter.samhsa.gov/pdfs/ebp/TraumaSpecificInterventions.pdf>
- SAMHSA. *SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach*.
<http://gainscenter.samhsa.gov/cms-assets/documents/200917-603321.sma14-4884.pdf>

Veterans

- SAMHSA's GAINS Center. *Responding to the Needs of Justice-Involved Combat Veterans with Service-Related Trauma and Mental Health Conditions*.
http://gainscenter.samhsa.gov/pdfs/veterans/CVTJS_Report.pdf
- Justice for Vets. *Ten Key Components of Veterans Treatment Courts*.
<http://justiceforvets.org/sites/default/files/files/Ten%20Key%20Components%20of%20Veterans%20Treatment%20Courts%20.pdf>

APPENDIX INDEX

Appendix 1 Sequential Intercept Mapping Workshop Participant List (June 24-25, 2015)

Appendix 2 Texas Department of State Health Services. *Crisis Services*.

Appendix 3 Corporation for Supportive Housing. *Jail Data Link Frequent Users: A Data Matching Initiative in Illinois*.

Appendix 4 Dennis, D., Ware, D., and Steadman, H.J. (2014). Best Practices for Increasing Access to SSI and SSDI on Exit from Criminal Justice Settings. *Psychiatric Services*, 65, 1081-1083.

Appendix 5 100,000 Homes/Center for Urban Community Services. *Housing First Self-Assessment: Assess and Align Your Program and Community with a Housing First Approach*.

Appendix 6 Reentry and Recidivism Studies (various).

Appendix 7 SAMHSA's GAINS Center for Behavioral Health and Justice Transformation. *Housing Options for Persons with Mental Illness Involved with the Criminal Justice System*.

Appendix 8 Action Planning Chart Template (To use for more detailed post-SIM strategic planning and efforts toward addressing the priorities discussed).

Appendix 1: SIM Participant List

First Name	Last Name	Email	Position	Agency/Organization
Sandy	Pasch	pasch.sandy@gmail.com	(former) Elected Official/Advocate	(former) Elected Official
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Jeffrey	Altenburg	Jeffrey.Altensburg@da.wi.gov	Deputy District Attorney	Milwaukee District Attorney's Office
Jennifer	Wittwer	jennifer.wittwer@milwaukeecountywi.gov	Associate Director	Community Access to Recovery Services Behavioral Health Division
Brenda	Wesley			

Appendix 2: Crisis Services

Crisis Services

The Department of State Health Services (DSHS) funds 37 LMHAs and NorthSTAR to provide an array of ongoing and crisis services to individuals with mental illness. Laws and rules governing DSHS and the delivery of mental health services require LMHAs and NorthSTAR to provide crisis screening and assessment. Newly appropriated funds enhanced the response to individuals in crisis.

The 80th Legislature

\$82 million was appropriated for the FY 08-09 biennium for improving the response to mental health and substance abuse crises. A majority of the funds were divided among the state's Local Mental Health Authorities (LMHAs) and added to existing contracts. The first priority for this portion of the funds was to support a rapid community response to offset utilization of emergency rooms or more restrictive settings.

Crisis Funds

- **Crisis Hotline Services**
 - Continuously available 24 hours per day, seven days per week
 - All 37 LMHAs and NorthSTAR have or contract with crisis hotlines that are accredited by the American Association of Suicidology (AAS)
- **Mobile Crisis Outreach Teams (MCOT)**
 - Operate in conjunction with crisis hotlines
 - Respond at the crisis site or a safe location in the community
 - All 37 LMHAs and NorthSTAR have MCOT teams
 - More limited coverage in some rural communities

\$17.6 million dollars of the initial appropriation was designated as community investment funds. The funds allowed communities to develop or expand local alternatives to incarceration or State hospitalization. Funds were awarded on a competitive basis to communities able to contribute at least 25% in matching resources. Sufficient funds were not available to provide expansion in all communities served by the LMHAs and NorthSTAR.

Competitive Funds Projects

- **Crisis Stabilization Units (CSU)**
 - Provide immediate access to emergency psychiatric care and short-term residential treatment for acute symptoms
 - Two CSUs were funded
- **Extended Observation Units**
 - Provide 23-48 hours of observation and treatment for psychiatric stabilization
 - Three extended observation units were funded
- **Crisis Residential Services**
 - Provide from 1-14 days crisis services in a clinically staffed, safe residential setting for individuals with some risk of harm to self or others
 - Four crisis residential units were funded
- **Crisis Respite Services**

- Provide from 8 hours up to 30 days of short-term, crisis care for individuals with low risk of harm to self or others
- Seven crisis respite units were funded
- **Crisis Step-Down Stabilization in Hospital Setting**
 - Provides from 3-10 days of psychiatric stabilization in a psychiatrically staffed local hospital setting
 - Six local step-down stabilization beds were funded
- **Outpatient Competency Restoration Services**
 - Provide community treatment to individuals with mental illness involved in the legal system
 - Reduces unnecessary burdens on jails and state psychiatric hospitals
 - Provides psychiatric stabilization and participant training in courtroom skills and behavior
 - Four Outpatient Competency Restoration projects were funded

The 81st Legislature

\$53 million was appropriated for the FY 2010-2011 biennium for transitional and intensive ongoing services.

- **Transitional Services**
 - Provides linkage between existing services and individuals with serious mental illness not linked with ongoing care
 - Provides temporary assistance and stability for up to 90 days
 - Adults may be homeless, in need of substance abuse treatment and primary health care, involved in the criminal justice system, or experiencing multiple psychiatric hospitalizations
- **Intensive Ongoing Services for Children and Adults**
 - Provides team-based Psychosocial Rehabilitation services and Assertive Community Treatment (ACT) services (Service Package 3 and Service Package 4) to engage high need adults in recovery-oriented services
 - Provides intensive, wraparound services that are recovery-oriented to address the child's mental health needs
 - Expands availability of ongoing services for persons entering mental health services as a result of a crisis encounter, hospitalization, or incarceration

Appendix 3: CSH Jail Data Link

Overview of the Initiative

The Corporation for Supportive Housing (CSH) has funded the expansion of a data matching initiative at Cook County Jail designed to identify users of both Cook County Jail and the State of Illinois Division of Mental Health (DMH).

This is a secure internet based database that assists communities in identifying frequent users of multiple systems to assist them in coordinating and leveraging scarce resources more effectively. Jail Data Link helps staff at a county jail to identify jail detainees who have had past contact with the state mental health system for purposes of discharge planning. This system allows both the jail staff and partnering case managers at community agencies to know when their current clients are in the jail. Jail Data Link, which began in Cook County in 1999, has expanded to four other counties as a result of funding provided by the Illinois Criminal Justice Information Authority and will expand to three additional counties in 2009. In 2008 the Proviso Mental Health Commission funded a dedicated case manager to work exclusively with the project and serve the residents of Proviso Township.

Target Population for Data Link Initiatives

This project targets people currently in a county jail who have had contact with the Illinois Division of Mental Health.

- **Jail Data Link – Cook County:** Identifies on a daily basis detainees who have had documented inpatient/outpatient services with the Illinois Division of Mental Health. Participating agencies sign a data sharing agreement for this project.
- **Jail Data Link – Cook County Frequent Users:** Identifies those current detainees from the Cook County Jail census who have at least two previous State of Illinois psychiatric inpatient hospitalizations and at least two jail stays. This will assist the jail staff in targeting new housing resources as a part of a federally funded research project beginning in 2008.
- **Jail Data Link – Expansion:** The Illinois Criminal Justice Information Authority provided funding to expand the project to Will, Peoria, Jefferson and Marion Counties, and the Proviso Mental Health Commission for Proviso Township residents.

Legal Basis for the Data Matching Initiative

Effective January 1, 2000, the Illinois General Assembly adopted **Public Act 91-0536** which modified the Mental Health and Developmental Disabilities Administrative Act. This act allows the Division of Mental Health, community agencies funded by DMH, and any Illinois county jail to disclose a recipient's record or communications, without consent, to each other, for the purpose of admission, treatment, planning, or discharge. No records may be disclosed to a county jail unless the Department has entered into a written agreement with the specific county jail. Effective July 12, 2005, the Illinois General Assembly also adopted **Public Act 094-0182**, which further modifies the Mental Health and Developmental Disabilities Administrative Act to allow sharing between the Illinois Department of Corrections and DMH.

Using this exception, individual prisons or jails are able to send their entire roster electronically to DMH. Prison and jail information is publically available. DMH matches this information against their own roster and notifies the Department of Corrections Discharge Planning Unit of matches between the two systems along with information about past history and/or involvement with community agencies for purposes of locating appropriate aftercare services.

Sample Data at a Demo Web Site

DMH has designed a password protected web site to post the results of the match and make those results accessible to the Illinois Department of Corrections facility. Community agencies are also able to view the names of their own clients if they have entered into a departmental agreement to use the site.

In addition, DMH set up a demo web site using encrypted data to show how the data match web site works. Use the web site link below and enter the User ID, Password, and PIN number to see sample data for the Returning Home Initiative.

- <https://sisonline.dhs.state.il.us/JailLink/demo.html>
 - UserID: cshdemo
 - Password: cshdemo
 - PIN: 1234

Program Partners and Funding Sources

- **CSH's Returning Home Initiative:** Utilizing funding from the Robert Wood Johnson Foundation, provided \$25,000 towards programming and support for the creation of the Jail Data Link Frequent Users application.
- **Illinois Department of Mental Health:** Administering and financing on-going mental health services and providing secure internet database resource and maintenance.
- **Cermak Health Services:** Providing mental health services and supervision inside the jail facility.
- **Cook County Sheriff's Office:** Assisting with data integration and coordination.
- **Community Mental Health Agencies:** Fourteen (14) agencies statewide are entering and receiving data.
- **Illinois Criminal Justice Authority:** Provided funding for the Jail Data Link Expansion of data technology to three additional counties, as well as initial funding for three additional case managers and the project's evaluation and research through the University of Illinois.
- **Proviso Township Mental Health Commission (708 Board):** Supported Cook County Jail Data Link Expansion into Proviso Township by funding a full-time case manager.
- **University of Illinois:** Performing ongoing evaluation and research

Partnership Between Criminal Justice and Other Public Systems

Cook County Jail and Cermak Health Service have a long history of partnerships with the Illinois Department of Mental Health Services. Pilot projects, including the Thresholds Justice Project and the Felony Mental Health Court of Cook County, have received recognition for developing alternatives to the criminal justice system. Examining the systematic and targeted use of housing as an intervention is a logical extension of this previous work.

Managing the Partnership

CSH is the primary coordinator of a large federal research project studying the effects of permanent supportive housing on reducing recidivism and emergency costs of frequent users of Cook County Jail and the Illinois Department of Mental Health System. In order to facilitate this project, CSH funded the development of a new version of Jail Data Link to find the most frequent users of the jail and mental health inpatient system to augment an earlier version of Data Link in targeting subsidized housing and supportive mental health services.

About CSH and the Returning Home Initiative

The Corporation for Supportive Housing (CSH) is a national non-profit organization and Community Development Financial Institution that helps communities create permanent housing with services to prevent and end homelessness. Founded in 1991, CSH advances its mission by providing advocacy, expertise, leadership, and financial resources to make it easier to create and operate supportive housing. CSH seeks to help create an expanded supply of supportive housing for people, including single adults, families with children, and young adults, who have extremely low-incomes, who have disabling conditions, and/or face other significant challenges that place them at on-going risk of homelessness. For information regarding CSH's current office locations, please see www.csh.org/contactus.

CSH's national *Returning Home Initiative* aims to end the cycle of incarceration and homelessness that thousands of people face by engaging the criminal justice systems and integrating the efforts of housing, human service, corrections, and other agencies. *Returning Home* focuses on better serving people with histories of homelessness and incarceration by placing them to supportive housing.



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**Appendix 4:
Best Practices for
Increasing Access to
SSI/SSDI**



SSI/SSDI Outreach, Access and Recovery

for people who are homeless

January 2013

Best Practices for Increasing Access to SSI/SSDI upon Exiting Criminal Justice Settings

Dazara Ware, M.P.C. and Deborah Dennis, M.A.

Introduction

Seventeen percent of people currently incarcerated in local jails and in state and federal prisons are estimated to have a serious mental illness.¹ The twin stigmas of justice involvement and mental illness present significant challenges for social service staff charged with helping people who are incarcerated plan for reentry to community life. Upon release, the lack of treatment and resources, inability to work, and few options for housing mean that many quickly become homeless and recidivism is likely.

The Social Security Administration (SSA), through its Supplemental Security Income (SSI) and Social Security Disability Insurance (SSDI) programs, can provide income and other benefits to persons with mental illness who are reentering the community from jails and prisons. The SSI/SSDI Outreach, Access and Recovery program (SOAR), a project funded by the Substance Abuse and Mental Health Services Administration, is a national technical assistance program that helps people who are homeless or at risk for homelessness to access SSA disability benefits.²

SOAR training can help local corrections and community transition staff negotiate and integrate benefit options with community reentry strategies

for people with mental illness and co-occurring disorders to assure successful outcomes. This best practices summary describes:

- The connections between mental illness, homelessness, and incarceration;
- The ramifications of incarceration on receipt of SSI and SSDI benefits
- The role of SOAR in transition planning
- Examples of jail or prison SOAR initiatives to increase access to SSI/SSDI
- Best practices for increasing access to SSI/SSDI benefits for people with mental illness who are reentering the community from jails and prisons.

Mental Illness, Homelessness, and Incarceration

In 2010, there were more than 7 million persons under correctional supervision in the United States at any given time.³ Each year an estimated 725,000 persons are released from federal and state prisons, 125,000 with serious mental illness.⁴ More than 20 percent of people with mental illness were homeless in the months before their incarceration compared

¹ Bureau of Justice Statistics. (2006). *Mental health problems of prison and jail inmates*. Washington, DC: U.S. Department of Justice, Office of Justice Programs

² Dennis, D., Lassiter, M., Connelly, W., & Lupfer, K. (2011) Helping adults who are homeless gain disability benefits: The SSI/SSDI Outreach, Access and Recovery (SOAR) program. *Psychiatric Services*, 62(11)1373-1376

³ Guerino, P.M. Harrison & W. Sabel. *Prisoners in 2010*. NCJ 236096. Washington DC: U.S. Department of Justice, Bureau of Justice Statistics, 2011.

⁴ Glaze, L. *Correctional populations in the U.S. 2010*, NCJ 236319. Washington D.C.: U.S. Department of Justice, Bureau of Justice Statistics 2011

with 10 percent of the general prison population.⁵ For those exiting the criminal justice system, homelessness may be even more prevalent. A California study, for example, found that 30 to 50 percent of people on parole in San Francisco and Los Angeles were homeless.⁶

Mental Health America reports that half of people with mental illness are incarcerated for committing nonviolent crimes, such as trespassing, disorderly conduct, and other minor offences resulting from symptoms of untreated mental illness. In general, people with mental illnesses remain in jail eight times longer than other offenders at a cost that is seven times higher.⁷ At least three-quarters of incarcerated individuals with mental illness have a co-occurring substance use disorder.⁸

Homelessness, mental illness, and criminal justice involvement create a perfect storm, requiring concerted effort across multiple systems to prevent people with mental illness from cycling between homelessness and incarceration by providing them the opportunity to reintegrate successfully into their communities and pursue recovery.

To understand the interplay among mental illness, homelessness, and incarceration, consider these examples:

- In 2011 Sandra received SSI based on her mental illness. She was on probation, with three years remaining, when she violated the terms of probation by failing to report to her probation officer. As a result, Sandra was incarcerated in a state prison. Because she was incarcerated for more than 12 months, her benefits were terminated. Sandra received a tentative parole month of

September 2012 contingent on her ability to establish a verifiable residential address. The parole board did not approve the family address she submitted because the location is considered a high crime area. Unfortunately, Sandra was unable to establish residency on her own as she had no income. Thus, she missed her opportunity for parole and must complete her maximum sentence. Sandra is scheduled for release in 2013.

- Sam was released from prison after serving four years. While incarcerated, he was diagnosed with a traumatic brain injury and depression. Sam had served his full sentence and was not required to report to probation or parole upon release. He was released with \$25 and the phone number for a community mental health provider. Sam is 27 years old with a ninth grade education and no prior work history. He has no family support. Within two weeks of release, Sam was arrested for sleeping in an abandoned building. He was intoxicated and told the arresting officer that drinking helped the headaches he has suffered from since he was 14 years old. Sam was sent to jail.
- Manuel was arrested for stealing from a local grocery store. He was homeless at the time of arrest and had a diagnosis of schizophrenia. He was not receiving any community mental health services at the time. Manuel has no family. He was sent to a large county jail where he spent two years before being arraigned before a judge. His periodic acute symptoms resulted in his being taken to the state hospital until he was deemed stable enough to stand trial. However, the medications that helped Manuel's symptoms in the hospital weren't approved for use in the jail, and more acute episodes followed. Manuel cycled between the county jail and the state hospital four times over a two-year period before being able to stand before a judge.

Based on real life situations, these examples illustrate the complex needs of people with serious mental illnesses who become involved with the justice system. In Sandra's and Sam's cases, the opportunity to apply for SSI/SSDI benefits on a pre-release basis would have substantially reduced the period of incarceration, and in Manuel's case, access to SSI immediately upon release would have decreased the likelihood he would return to jail. But how do we ensure that this happens?

⁵ *Reentry Facts*. The National Reentry Resource Center. Council of State Governments Justice Center. Retrieved December 6, 2012, from <http://www.nationalreentryresourcecenter.org/facts>

⁶ California Department of Corrections. (1997). *Preventing Parolee Failure Program: An evaluation*. Sacramento: Author.

⁷ Mental Health America. (2008). *Position Statement 52: In support of maximum diversion of persons with serious mental illness from the criminal justice system*. Retrieved from <http://www.mentalhealthamerica.net>.

⁸ Council of State Governments. (2002). *Criminal Justice/ Mental Health Consensus Project*. Lexington, Kentucky: author.

Incarceration and SSA Disability Benefits

Correctional facilities, whether jails or prisons, are required to report to SSA newly incarcerated people who prior to incarceration received benefits. For each person reported, SSA sends a letter to the facility verifying the person's benefits have been suspended and specifying the payment to which the facility is entitled for providing this information. SSA pays \$400 for each person reported by the correctional facility within 60 days. If a report is made between 60 and 90 days of incarceration, SSA pays \$200. After 90 days, no payment is made.

The rules for SSI and SSDI beneficiaries who are incarcerated differ. Benefits for SSI recipients incarcerated for a full calendar month are suspended, but if the person is released within 12 months, SSI is reinstated upon release if proof of incarceration and a release are submitted to the local SSA office. SSA reviews the individual's new living arrangements, and if deemed appropriate, SSI is reinstated. However, if an SSI recipient is incarcerated for 12 or more months, SSI benefits are terminated and the individual must reapply. Reapplication can be made 30 days prior to the expected release date, but benefits cannot begin until release.

Unfortunately, people who are newly released often wait months before their benefits are reinstated or initiated. Few states or communities have developed legislation or policy to insure prompt availability of benefits upon release. Consequently, the approximately 125,000 people with mental illness who are released each year are at increased risk for experiencing symptoms of mental illness, substance abuse, homelessness, and recidivism.

SSDI recipients are eligible to continue receiving benefits until convicted of a criminal offense and confined to a penal institution for more than 30 continuous days. At that time, SSDI benefits are suspended but will be reinstated the month following release.

Role of Transition Services in Reentry for People with Mental Illness

Since the 1990s, the courts have increasingly acknowledged that helping people improve their mental health and their ability to demonstrate safe and orderly behaviors while they are incarcerated enhances their reintegration and the well-being of the communities that receive them. Courts specializing in the needs of people with mental illness and or substance use disorders, people experiencing homelessness, and veterans are designed to target the most appropriate procedures and service referrals to these individuals, who may belong to more than one subgroup. The specialized courts and other jail diversion programs prompt staff of various systems to consider reintegration strategies for people with mental illness from the outset of their criminal justice system involvement. Transition and reintegration services for people with mental illness reflect the shared responsibilities of multiple systems to insure continuity of care.

Providing transition services to people with mental illness within a jail or prison setting is difficult for several reasons: the quick population turnover in jails, the distance between facilities and home communities for people in prisons, the comprehensive array of services needed to address multiple needs, and the perception that people with mental illness are not responsive to services. Nevertheless, without seriously addressing transition and reintegration issues while offenders remain incarcerated, positive outcomes are far less likely upon release and recidivism is more likely.

Access to Benefits as an Essential Strategy for Reentry

The criminal justice and behavioral health communities consistently identify lack of timely access to income and other benefits, including health insurance, as among the most significant and persistent barriers to successful community reintegration and recovery for people with serious mental illnesses and co-occurring substance use disorders.

Many states and communities that have worked to ensure immediate access to benefits upon release have focused almost exclusively on Medicaid. Although access to Medicaid is critically important, focusing on this alone often means that needs for basic sustenance and housing are ignored. Only a few states (Oregon, Illinois, New York, Florida) provide for Medicaid to be suspended upon incarceration rather than terminated, and few states or communities have developed procedures to process new Medicaid applications prior to release.

The SOAR approach to improving access to SSI/SSDI. The SSI/SSDI application process is complicated and difficult to navigate, sometimes even for professional social service staff. The SOAR approach in correctional settings is a collaborative effort by corrections, behavioral health, and SSA to address the need for assistance to apply for these benefits. On average, providers who receive SOAR training achieve a first-time approval rate of 71 percent, while providers who are not SOAR trained or individuals who apply unassisted achieve a rate of 10 to 15 percent.⁹ SOAR-trained staff learn how to prepare comprehensive, accurate SSI/SSDI applications that are more likely to be approved, and approved quickly.

SOAR training is available in every state. The SOAR Technical Assistance Center, funded by SAMHSA, facilitates partnerships with community service providers to share information, acquire pre-incarceration medical records, and translate prison functioning into post-release work potential. With SOAR training, social service staff learn new observation techniques to uncover information critical to developing appropriate reentry strategies. The more accurate the assessment of factors indicating an individual's ability to function upon release, the easier it is to help that person transition successfully from incarceration to community living.

The positive outcomes produced by SOAR pilot projects within jail and prison settings around the country that link people with mental illness to benefits upon their release should provide impetus for more correctional facilities to consider using this approach as a foundation for building successful transition or

reentry programs.¹⁰ Below are examples of SOAR collaborations in jails (Florida, Georgia, and New Jersey) and prison systems (New York, Oklahoma, and Michigan). In addition to those described below, new SOAR initiatives are underway in the jail system of Reno, Nevada and in the prison systems of Tennessee, Colorado, Connecticut, and the Federal Bureau of Prisons.

SOAR Collaborations with Jails

Eleventh Judicial Circuit Criminal Mental Health Project (CMHP). Miami-Dade County, Florida, is home to the highest percentage of people with serious mental illnesses of any urban area in the United States – approximately nine percent of the population, or 210,000 people. CMHP was established in 2000 to divert individuals with serious mental illnesses or co-occurring substance use disorders from the criminal justice system into comprehensive community-based treatment and support services. CMHP staff, trained in the SOAR approach to assist with SSI/SSDI applications, developed a strong collaborative relationship with SSA to expedite and ensure approvals for entitlement benefits in the shortest time possible. All CMHP participants are screened for eligibility for SSI/SSDI.

From July 2008 through November 2012, 91 percent of 181 individuals were approved for SSI/SSDI benefits on initial application in an average of 45 days. All participants of CMHP are linked to psychiatric treatment and medication with community providers upon release from jail. Community providers are made aware that participants who are approved for SSI benefits will have access to Medicaid and retroactive reimbursement for expenses incurred for up to 90 days prior to approval. This serves to reduce the stigma of mental illness and involvement with the criminal justice system, making participants more attractive “paying customers.”

In addition, based on an agreement established between Miami-Dade County and SSA, interim housing assistance is provided for individuals applying for SSI/SSDI during the period between application and

⁹ Dennis et al., (2011). *op cit*.

¹⁰ Dennis, D. & Abreu, D. (2010) SOAR: Access to benefits enables successful reentry, *Corrections Today*, 72(2), 82–85.

approval. This assistance is reimbursed to the County once participants are approved for Social Security benefits and receive retroactive payment. The number of arrests two years after receipt of benefits and housing compared to two years earlier was reduced by 70 percent (57 versus 17 arrests).

Mercer and Bergen County Correctional Centers, New Jersey. In 2011, with SOAR training and technical assistance funded by The Nicholson Foundation, two counties in New Jersey piloted the use of SOAR to increase access to SSI/SSDI for persons with disabilities soon to be released from jail. In each county, a collaborative working group comprising representatives from the correctional center, community behavioral health, SSA, the state Disability Determination Service (DDS), and (in Mercer County only) the United Way met monthly to develop, implement, and monitor a process for screening individuals in jail or recently released and assisting those found potentially eligible in applying for SSI/SSDI. The community behavioral health agency staff, who were provided access to inmates while incarcerated and to jail medical records, assisted with applications.

During the one year evaluation period for Mercer County, 89 individuals from Mercer County Correction Center were screened and 35 (39 percent) of these were deemed potentially eligible for SSI/SSDI. For Bergen County, 69 individuals were screened, and 39 (57 percent) were deemed potentially eligible. The reasons given for not helping some potentially eligible individuals file applications included not enough staff available to assist with application, potential applicant discharged from jail and disappeared/couldn't locate, potential applicant returned to prison/jail, and potential applicant moved out of the county or state. In Mercer County, 12 out of 16 (75 percent) SSI/SSDI applications were approved on initial application; two of those initially denied were reversed at the reconsideration level without appeal before a judge. In Bergen County which had a late start, two out of three former inmates assisted were approved for SSI/SSDI.

Prior to this pilot project, neither behavioral health care provider involved had assisted with SSI/SSDI applications for persons re-entering the community from the county jail. After participating in the pilot project, both agencies remain committed to continuing

such assistance despite the difficulty of budgeting staff time for these activities.

Fulton County Jail, Georgia. In June 2009, the Georgia Department of Behavioral Health and Developmental Disabilities initiated a SOAR pilot project at the Fulton County Jail. With the support of the facility's chief jailer, SOAR staff were issued official jail identification cards that allowed full and unaccompanied access to potential applicants. SOAR staff worked with the Office of the Public Defender and received referrals from social workers in this office. They interviewed eligible applicants at the jail, completed SSI/SSDI applications, and hand-delivered them to the local SSA field office. Of 23 applications submitted, 16 (70 percent) were approved within an average of 114 days.

SOAR benefits specialists approached the Georgia Department of Corrections with outcome data produced in the Fulton County Jail pilot project to encourage them to use SOAR in the state prison system for persons with mental illness who were coming up for release. Thirty-three correctional officers around the state received SOAR training and were subsequently assigned by the Department to work on SSI/SSDI applications.

SOAR Collaborations with State and Federal Prisons

New York's Sing Sing Correctional Facility. The Center for Urban and Community Services was funded by the New York State Office of Mental Health, using a Projects for Assistance in Transition from Homelessness (PATH) grant, to assist with applications for SSI/SSDI and other benefits for participants in a 90-day reentry program for persons with mental illness released from New York State prisons. After receiving SOAR training and within five years of operation, the Center's Community Orientation and Reentry Program at the state's Sing Sing Correctional Facility achieved an approval rate of 87 percent on 183 initial applications, two thirds of which were approved prior to or within one month of release.

Oklahoma Department of Corrections. The Oklahoma Department of Corrections and the Oklahoma Department of Mental Health collaborated

to initiate submission of SSI/SSDI applications using SOAR-trained staff. Approval rates for initial submission applications are about 90 percent. The Oklahoma SOAR program also uses peer specialists to assist with SSI/SSDI applications for persons exiting the prison system. Returns to prison within 3 years were 41 percent lower for those approved for SSI/SSDI than a comparison group.

Michigan Department of Corrections. In 2007 the Michigan Department of Corrections (DOC) began to discuss implementing SOAR as a pilot in a region where the majority of prisoners with mental illnesses are housed. A subcommittee of the SOAR State Planning Group was formed and continues to meet monthly to address challenges specific to this population. In January 2009, 25 DOC staff from eight facilities, facility administration, and prisoner reentry staff attended a two-day SOAR training. The subcommittee has worked diligently to develop a process to address issues such as release into the community before a decision is made by SSA, the optimal time to initiate the application process, and collaboration with local SSA and DDS offices.

Since 2007, DOC has received 72 decisions on SSI/SSDI applications with a 60 percent approval rate in an average of 105 days. Thirty-nine percent of applications were submitted after the prisoner was released, and 76 percent of the decisions were received after the applicant's release. Seventeen percent of those who were denied were re-incarcerated within the year following release while only two percent of those who were approved were re-incarcerated.

Park Center's Facility In-Reach Program. Park Center is a community mental health center in Nashville, Tennessee. In July 2010, staff began assisting with SSI/SSDI applications for people with mental illness in the Jefferson County Jail and several facilities administered by the Tennessee Department of Corrections, including the Lois M. DeBerry Special Needs Prison and the Tennessee Prison for Woman. From July 2010 through November 2012, 100 percent of 44 applications have been approved in an average of 41 days. In most cases, Park Center's staff assisted with SSI/SSDI applications on location in these facilities prior to release. Upon release, the individual is accompanied by Park Center staff to the local SSA

office where their release status is verified and their SSI/SSDI benefits are initiated.

Best Practices for Accessing SSI/SSDI as an Essential Reentry Strategy

The terms jail and prison are sometimes used interchangeably, but it is important to understand the distinctions between the two. Generally, a jail is a local facility in a county or city that confines adults for a year or less. Prisons are administered by the state or federal government and house persons convicted and sentenced to serve time for a year or longer.

Discharge from both jails and prisons can be unpredictable, depending on a myriad of factors that may be difficult to know in advance. Working with jails is further complicated by that fact that they generally house four populations: (1) people on a 24-48 hour hold, (2) those awaiting trial, (3) those sentenced and serving time in jail, and (4) those sentenced and awaiting transfer to another facility, such as a state prison.

Over the past several years, the following best practices have emerged with respect to implementing SOAR in correctional settings. These best practices are in addition to the critical components required by the SOAR model for assisting with SSI/SSDI applications.¹¹ These best practices fall under five general themes:

- Collaboration
- Leadership
- Resources
- Commitment
- Training

Collaboration. The SOAR approach emphasizes collaborative efforts to help staff and their clients navigate SSA and other supports available to people with mental illness upon their release. Multiple collaborations are necessary to make the SSI/SSDI application process work. Fortunately, these are the same collaborations necessary to make the overall transition work. Thus, access to SSI/SSDI can become

¹¹ See <http://www.prainc.com/soar/criticalcomponents>.

a concrete foundation upon which to build the facility's overall discharge planning or reentry process.

- **Identify stakeholders.** Potential stakeholders associated with jail/prisons include
 - ✓ Judges assigned to specialized courts and diversion programs
 - ✓ Social workers assigned to the public defenders' office
 - ✓ Chief jailers or chiefs of security
 - ✓ Jail mental health officer, psychologist, or psychiatrist
 - ✓ County or city commissioners
 - ✓ Local reentry advocacy project leaders
 - ✓ Commissioner of state department of corrections
 - ✓ State director of reintegration/reentry services
 - ✓ Director of medical or mental health services for state department of corrections
 - ✓ State mental health agency administrator
 - ✓ Community reentry project directors
 - ✓ Parole/probation managers
- **Collaborate with SSA to establish prerelease agreements.** SSA can establish prerelease agreements with correctional facilities to permit special procedures when people apply for benefits prior to their release and will often assign a contact person. For example, prerelease agreements can be negotiated to allow for applications to be submitted from 60 to 120 days before the applicant's expected release date. In addition, SSA can make arrangements to accept paper applications and schedule phone interviews when necessary.
- **Collaborate with local SOAR providers to establish continuity of care.** Given the unpredictability of release dates from jails and prisons, it is important to engage a community-based behavioral health provider to either begin the SSI/SSDI application process while the person is incarcerated or to assist with the individual's reentry and assume responsibility for completing his or her SSI/SSDI application following release. SOAR training can help local corrections and community transition staff assure continuity of care by determining and coordinating benefit options and reintegration strategies for people with mental illness. Collaboration among service

providers, including supported housing programs that offer a variety of services, is key to assuring both continuity of care and best overall outcomes post-release.

- **Collaborate with jail or prison system for referrals, access to inmates, and medical records.** Referrals for a jail or prison SOAR project can issue from many sources – intake staff, discharge planners, medical or psychiatric unit staff, judges, public defenders, parole or probation, and community providers. Identifying persons within the jail or prison who may be eligible for SSI/SSDI requires time, effort, and collaboration on the part of the jail or prison corrections and medical staff.

Once individuals are identified as needing assistance with an SSI/SSDI application, they can be assisted by staff in the jail or prison, with a handoff occurring upon release, or they can be assisted by community providers who come into the facility for this purpose. Often, correctional staff, medical or psychiatric staff, and medical records are administered separately and collaborations must be established within the facility as well as with systems outside it.

Leadership. Starting an SSI/SSDI initiative as part of transition planning requires leadership in the form of a steering committee, with a strong and effective coordinator, that meets regularly. The Mercer County, New Jersey SOAR Coordinator, for example, resolves issues around SSI/SSDI applications that are brought up at case manager meetings, oversees the quality of applications submitted, organizes trainings, and responds to concerns raised by SSA and DDS.

The case manager meetings are attended by the steering committee coordinator who serves as a liaison between the case managers and steering committee. Issues identified by case managers typically require additional collaborations that must be approved at the steering committee level. Leadership involves frequent, regular, and ad hoc communication among all parties to identify and resolve challenges that arise.

It is essential that the steering committee include someone who has authority within the jail or prison system as well as someone with a clinical background who can assure that the clinical aspects of implementation are accomplished (e.g., mental status

exams with 90 days of application, access to records, physician or psychologist sign off on medical summary reports).

Resources. Successful initiatives have committed resources for staffing at two levels. First, staff time is needed to coordinate the overall effort. In the Mercer County example above, the steering committee coordinator is a paid, part-time position. If there is someone charged with overall transition planning for the facility, the activities associated with implementing assistance with SSI/SSDI may be assumed by this individual.

Second, the staff who are assisting with SSI/SSDI applications need to be trained (typically 1-2 days) and have time to interview and assess the applicant, gather and organize the applicant's medical records, complete the SSA forms, and write a supporting letter that documents how the individual's disability or disabilities affect his or her ability to work. Full-time staff working only on SSI/SSDI applications can be expected to complete about 50-60 applications per year using the SOAR approach. Assisting with SSI/SSDI applications cannot be done efficiently without dedicated staffing.

Finally, our experience has shown that it is difficult for jail staff to assist with applications in the jail due to competing demands, staffing levels, skill levels of the staff involved, and staff turnover. Without community providers, there would be few or no applications completed for persons coming out of jails in the programs with which we have worked. Jail staff time may be best reserved for: (1) identifying and referring individuals who may need assistance to community providers; (2) facilitating community provider access to inmates prior to release from jail; and (3) assistance with access to jail medical records.

Commitment. Developing and implementing an initiative to access SSI/SSDI as part of transition planning requires a commitment by the jail or prison's administration for a period of at least a year to see results and at least two years to see a fully functioning program. During the start up and early implementation period, competing priorities can often derail the best intentions. We have seen commitment wane as new administrations took office and the department of corrections commissioner changed. We have seen

staff struggle without success to find time to assist with applications as part of the job they are already doing. We have seen many facilities, particularly state departments of corrections, willing to conduct training for staff, but unwilling or unable to follow through on the rest of what it takes to assist with SSI/SSDI applications.

Training. Training for staff in jails and prisons should include staff who identify and refer people for assistance with SSI/SSDI applications, staff who assist with completing the applications, medical records staff, and physicians/psychologists. The depth and length of training for each of these groups will vary. However, without the other elements discussed above in place, training is of very limited value.

Training in the SOAR approach for jail and prison staff has been modified to address the assessment and documentation of functioning in correctional settings. Training must cover the specific referral and application submission process established by the steering group in collaboration with SSA and DDS to ensure that applications submitted are consistent with expectations, procedures are subject to quality review, and outcomes of applications are tracked and reported. It is important that training take place after plans to incorporate each of these elements have been determined by the steering committee.

Conclusion

People with mental illness face extraordinary barriers to successful reentry. Without access to benefits, they lack the funds to pay for essential mental health and related services as well as housing. The SOAR approach has been implemented in 50 states, and programmatic evidence demonstrates the approach is transferable to correctional settings. Acquiring SSA disability benefits and the accompanying Medicaid/Medicare benefit provides the foundation for reentry plans to succeed.

For More Information

To find out more about SOAR in your state or to start SOAR in your community, contact the national SOAR technical assistance team at soar@prainc.com or check out the SOAR website at <http://www.prainc.com/soar>.

**Appendix 5:
Housing First
Self-Assessment**

Housing First Self-Assessment

Assess and Align Your Program and Community
with a Housing First Approach

**100,000
HOMES**



HIGH PERFORMANCE SERIES

The 100,000 Homes Campaign team identified a cohort of factors that are correlated with higher housing placement rates across campaign communities. The purpose of this High Performance Series of tools is to spotlight best practices and expand the movement's peer support network by sharing this knowledge with every community.

This tool addresses Factor #4: *Evidence that the community has embraced a Housing First/Rapid Rehousing approach system-wide.*

The full series is available at: <http://100khomes.org/resources/high-performance-series>

Housing First Self-Assessment

Assess and Align Your Program with a Housing First Approach

A community can only end homelessness by housing every person who is homeless, including those with substance use and mental health issues. Housing First is a proven approach for housing chronic and vulnerable homeless people. Is your program a Housing First program? Does your community embrace a Housing First model system-wide? To find out, use the Housing First self-assessments in this tool. We've included separate assessments for:

- Outreach programs
- Emergency shelter programs
- Permanent housing programs
- System and community level stakeholder groups

What is Housing First?

According to the National Alliance to End Homelessness, Housing First is an approach to ending homelessness that centers on providing homeless people with housing as quickly as possible – and then providing services as needed. Pioneered by **Pathways to Housing** (www.pathwaystohousing.org) and adopted by hundreds of programs throughout the U.S., Housing First practitioners have demonstrated that virtually all homeless people are “housing ready” and that they can be quickly moved into permanent housing before accessing other common services such as substance abuse and mental health counseling.

Why is this Toolkit Needed?

In spite of the fact that this approach is now almost universally touted as a solution to homelessness and Housing First programs exist in dozens of U.S. cities, few communities have adopted a Housing First approach on a systems-level. This toolkit serves as a starting point for communities who want to embrace a Housing First approach and allows individual programs and the community as a whole to identify where its practices are aligned with Housing First and what areas of its work to target for improvement to more fully embrace a Housing First approach. The toolkit consists of four self-assessments each of which can be completed in under 10 minutes:

- **Housing First in Outreach Programs Self-Assessment** (to be completed by outreach programs)
- **Housing First in Emergency Shelters Self-Assessment** (to be completed by emergency shelters)
- **Housing First in Permanent Supportive Housing Self-Assessment** (to be completed by supportive housing providers)
- **Housing First System Self-Assessment** (to be completed by community-level stakeholders such as Continuums of Care and/or government agencies charged with ending homelessness)

How Should My Community Use This Tool?

- **Choose the appropriate Housing First assessment(s)** – Individual programs should choose the assessment that most closely matches their program type while community-level stakeholders should complete the systems assessment
- **Complete the assessment and score your results** – Each assessment includes a simple scoring guide that will tell you the extent to which your program or community is implementing Housing First
- **Share your results with others in your program or community** – To build the political will needed to embrace a Housing First approach, share with other stakeholders in your community
- **Build a workgroup charged with making your program or community more aligned with Housing First** - Put together a work plan with concrete tasks, person(s) responsible and due dates for the steps your program and/or community needs to take to align itself with Housing First and then get started!
- **Send your results and progress to the 100,000 Homes Campaign** – We'd love to hear how you score and the steps you are taking to adopt a Housing First approach!

Who Does This Well?

The following programs in 100,000 Campaign communities currently incorporate Housing First principles into their everyday work:

- **Pathways to Housing** – www.pathwaystohousing.org
- **DESC** – www.desc.org
- **Center for Urban Community Services** – www.cucs.org

Many other campaign communities have also begun to prioritize the transition to a Housing First philosophy system-wide. Campaign contact information for each community is available at <http://100khomes.org/see-the-impact>

Related Tools and Resources

This toolkit was inspired the work done by several colleagues, including the National Alliance to End Homelessness, Pathways to Housing and the Department of Veterans Affairs. For more information on the Housing First efforts of these groups, please visit the following websites:

- **National Alliance to End Homelessness** – www.endhomelessness.org/pages/housingfirst
- **Pathways to Housing** – www.pathwaystohousing.org
- **Veterans Affairs (HUD VASH and Housing First, pages 170-182)** - http://www.va.gov/HOMELESS/docs/Center/144_HUD-VASH_Book_WEB_High_Res_final.pdf

For more information and support, please contact Erin Healy, Improvement Advisor - 100,000 Homes Campaign, at ehealy@cmtysolutions.org

Housing First Self-Assessment for Outreach Programs

1. Does your program receive real-time information about vacancies in Permanent Supportive Housing?

- **Yes** = 1 point
- **No** = 0 points

Number of Points Scored:

2. The entire process from street outreach (with an engaged client) to move-in to permanent housing typically takes:

- More than 180 days = 0 points
- Between 91 and 179 days = 1 point
- Between 61 and 90 days = 2 points
- Between 31 and 60 days = 3 points
- 30 days or less = 4 points
- Unknown = 0 points

Number of Points Scored:

3. Approximately what percentage of chronic and vulnerable homeless people served by your outreach program goes straight into permanent housing (without going through emergency shelter and transitional housing)?

- More than 75% = 5 points
- Between 51% and 75% = 4 points
- Between 26% and 50% = 3 points
- Between 11% and 25% = 2 points
- 10% or less = 1 point
- Unknown = 0 points

Number of Points Scored:

4. Indicate whether priority consideration for your program’s services is given to potential program participants with following characteristics. Check all that apply:

- Participants who demonstrate a high level of housing instability/chronic homelessness
- Participants who have criminal justice records, including currently on probation/parole/court mandate
- Participants who are actively using substances, including alcohol and illicit drugs Participants who do not engage in any mental health or substance treatment services
- Participants who demonstrate instability of mental health symptoms (NOT including those who present danger to self or others)

Checked Five = 5 points

Checked Four = 4 points

Checked Three = 3 points

Checked Two = 2 points

Checked One = 1 point

Checked Zero = 0 points

Total Points Scored:

To calculate your Housing First Score, add the total points scored for each question above, then refer to the key below:

Total Housing First Score:

If you scored: 13 points or more

- ✓ Housing First principles are likely being implemented ideally

If you scored between: 10 – 12 points

- ✓ Housing First principles are likely being well-implemented

If you scored between: 7 – 9 points

- ✓ Housing First principles are likely being fairly well-implemented

If you scored between: 4 - 6 points

- ✓ Housing First principles are likely being poorly implemented

If you scored between: 0 – 3 points

- ✓ Housing First principles are likely not being implemented

Housing First Self-Assessment For Emergency Shelter Programs

1. Does your program receive real-time information about vacancies in Permanent Supportive Housing?

- **Yes** = 1 point
- **No** = 0 points

Number of Points Scored:

2. Approximately what percentage of chronic and vulnerable homeless people staying in your emergency shelter go straight into permanent housing without first going through transitional housing?

- More than 75% = 5 points
- Between 51% and 75% = 4 points
- Between 26% and 50% = 3 points
- Between 11% and 25% = 2 points
- 10% or less = 1 point
- Unknown = 0 points

Number of Points Scored:

3. Indicate whether priority consideration for shelter at your program is given to potential program participants with following characteristics. Check all that apply:

- Participants who demonstrate a high level of housing instability/chronic homelessness
- Participants who have criminal justice records, including currently on probation/parole/court mandate
- Participants who are actively using substances, including alcohol and illicit drugs Participants who do not engage in any mental health or substance treatment services
- Participants who demonstrate instability of mental health symptoms (NOT including those who present danger to self or others)

Checked Five = 5 points

Checked Four = 4 points

Checked Three = 3 points

Checked Two = 2 points

Checked One = 1 point

Checked Zero = 0 points

Total Points Scored:

To calculate your Housing First Score, add the total points scored for each question above, then refer to the key below:

Total Housing First Score:

If you scored: 10 points or more

- ✓ Housing First principles are likely being implemented ideally

If you scored between: 6 – 9 points

- ✓ Housing First principles are likely being fairly well-implemented

If you scored between: 3 - 5 points

- ✓ Housing First principles are likely being poorly implemented

If you scored between: 0 – 2 points

- ✓ Housing First principles are likely not being implemented

Housing First Self-Assessment for Permanent Housing Programs

1. Does your program accept applicants with the following characteristics:

a) Active Substance Use

- Yes = 1 point
- No = 0 points

b) Chronic Substance Use Issues

- Yes = 1 point
- No = 0 points

c) Untreated Mental Illness

- Yes = 1 point
- No = 0 points

d) Young Adults (18-24)

- Yes = 1 point
- No = 0 points

e) Criminal Background (any)

- Yes = 1 point
- No = 0 points

f) Felony Conviction

- Yes = 1 point
- No = 0 points

g) Sex Offender or Arson Conviction

- Yes = 1 point
- No = 0 points

h) Poor Credit

- Yes = 1 point
- No = 0 points

i) No Current Source of Income (pending SSI/DI)

- Yes = 1 point
- No = 0 points

<u>Question Section</u>	<u># Points Scored</u>
Active Substance Use	
Chronic Substance Use Issues	
Untreated Mental Illness	
Young Adults (18-24)	
Criminal Background (any)	
Felony Conviction	
Sex Offender or Arson Conviction	
Poor Credit	
No Current Source of Income (pending SSI/DI)	
Total Points Scored in Question #1:	

2. Program participants are required to demonstrate housing readiness to gain access to units?

- No – Program participants have access to housing with no requirements to demonstrate readiness (other than provisions in a standard lease) = **3 points**
- Minimal – Program participants have access to housing with minimal readiness requirements, such as engagement with case management = **2 points**
- Yes – Program participant access to housing is determined by successfully completing a period of time in a program (e.g. transitional housing) = **1 point**
- Yes – To qualify for housing, program participants must meet requirements such as sobriety, medication compliance, or willingness to comply with program rules = **0 points**

Total Points Scored:

3. Indicate whether priority consideration for housing access is given to potential program participants with following characteristics. Check all that apply:

- Participants who demonstrate a high level of housing instability/chronic homelessness
- Participants who have criminal justice records, including currently on probation/parole/court mandate
- Participants who are actively using substances, including alcohol and illicit drugs (NOT including dependency or active addiction that compromises safety)
- Participants who do not engage in any mental health or substance treatment services
- Participants who demonstrate instability of mental health symptoms (NOT including those who present danger to self or others)

Checked Five = 5 points

Checked Four = 4 points

Checked Three = 3 points

Checked Two = 2 points

Checked One = 1 point

Checked Zero = 0 points

Total Points Scored:

4. Indicate whether program participants must meet the following requirements to ACCESS permanent housing. Check all that apply:

- Complete a period of time in transitional housing, outpatient, inpatient, or other institutional setting / treatment facility
- Maintain sobriety or abstinence from alcohol and/or drugs
- Comply with medication
- Achieve psychiatric symptom stability
- Show willingness to comply with a treatment plan that addresses sobriety, abstinence, and/or medication compliance
- Agree to face-to-face visits with staff

Checked Six = 0 points

Checked Five = 1 points

Checked Four = 2 points

Checked Three = 3 points

Checked Two = 4 points

Checked One = 5 point

Checked Zero = 6 points

Total Points Scored:

To calculate your Housing First Score, add the total points scored for each question above, then refer to the key below:

Total Housing First Score:

If you scored: 21 points or more

- ✓ Housing First principles are likely being implemented ideally

If you scored between: 15-20 points

- ✓ Housing First principles are likely being well-implemented

If you scored between: 10 – 14 points

- ✓ Housing First principles are likely being fairly well-implemented

If you scored between: 5 - 9 points

- ✓ Housing First principles are likely being poorly implemented

If you scored between: 0 – 4 points

- ✓ Housing First principles are likely not being implemented

Housing First Self-Assessment For Systems & Community-Level Stakeholders

1. Does your community set outcome targets around permanent housing placement for your outreach programs?

- Yes = 1 point
- No = 0 points

Number of Points Scored:

2. For what percentage of your emergency shelters does your community set specific performance targets related to permanent housing placement?

- 90% or more = 4 points
- Between 51% and 89% = 3 points
- Between 26% and 50% = 2 points
- 25% or less = 1 point
- Unknown = 0 points

Number of Points Scored:

3. Considering all of the funding sources for supportive housing, what percentage of your vacancies in existing permanent supportive housing units are dedicated for people who meet the definition of chronic and/or vulnerable homeless?

- 90% or more = 4 points
- Between 51% and 89% = 3 points
- Between 26% and 50% = 2 points
- 25% or less = 1 point
- Unknown = 0 points

Number of Points Scored:

4. Considering all of the funding sources for supportive housing, what percentage of new supportive housing units are dedicated for people who meet the definition of chronic and/or vulnerable homeless?

- 90% or more = 4 points
- Between 51% and 89% = 3 points
- Between 26% and 50% = 2 points
- Between 1% and 25% = 1 point
- 0% (we do not dedicate any units to this population) = 0 points
- Unknown = 0 points

Number of Points Scored:

5. Does your community have a formal commitment from your local Public Housing Authority to provide a preference (total vouchers or turn-over vouchers) for homeless individuals and/or families?

- Yes, a preference equal to 25% or more of total or turn-over vouchers = 4 points
- Yes, a preference equal to 10% - 24% or more of total or turn-over = 3 points
- Yes, a preference equal to 5% - 9% or more of total or turn-over = 2 points
- Yes, a preference equal to less than 5% or more of total or turn-over = 1 point
- No, we do not have an annual set-aside = 0 points
- Unknown = 0 points

Number of Points Scored:

6. Has your community mapped out its housing placement process from outreach to move-in (e.g. each step in the process as well as the average time needed for each step has been determined)?

- Yes = 1 point
- No = 0 points

Number of Points Scored:

7. Does your community have a Coordinated Housing Placement System or Single Point of Access into permanent supportive housing?

- Yes = 1 point
- Partial = ½ point
- No = 0 points

Number of Points Scored:

8. Does your community have a Coordinated Housing Placement System or Single Point of Access into permanent subsidized housing (e.g. Section 8 and other voucher programs)?

- Yes = 1 point
- Partial = ½ point
- No = 0 points

Number of Points Scored:

9. Does your community have different application/housing placement processes for different populations and/or different funding sources? If so, how many separate processes does your community have?

- 5 or more processes = 0 points
- 3-4 processes = 1 point
- 2 processes = 2 points
- 1 process for all populations = 3 points

Number of Points Scored:

10. The entire process from street outreach (with an engaged client) to move-in to permanent housing typically takes:

- More than 180 days = 0 points
- Between 91 and 179 days = 1 point
- Between 61 and 90 days = 2 points
- Between 31 and 60 days = 3 points
- 30 days or less = 4 points
- Unknown = 0 points

Number of Points Scored:

11. Approximately what percentage of homeless people living on the streets go straight into permanent housing (without going through emergency shelter and transitional housing)?

- More than 75% = 5 points
- Between 51% and 75% = 4 points
- Between 26% and 50% = 3 points
- Between 11% and 25% = 2 points
- 10% or less = 1 point
- Unknown = 0 points

Number of Points Scored:

12. Approximately what percentage of homeless people who stay in emergency shelters go straight into permanent housing without first going through transitional housing?

- More than 75% = 5 points
- Between 51% and 75% = 4 points
- Between 26% and 50% = 3 points
- Between 11% and 25% = 2 points
- 10% or less = 1 point
- Unknown = 0 points

Number of Points Scored:

13. Within a given year, approximately what percentage of your community's chronic and/or vulnerable homeless population who exit homelessness, exits into permanent supportive housing?

- More than 85% = 5 points
- Between 51% and 85% = 4 points
- Between 26% and 50% = 3 points
- Between 10% and 24% = 2 points
- Less than 10% = 1 point
- Unknown = 0 points

Number of Points Scored:

14. In a given year, approximately what percentage of your community's chronic and/or vulnerable homeless population exiting homelessness, exits to Section 8 or other long-term subsidy (with limited or no follow-up services)?

- More than 50% = 4 points
- Between 26% and 50% = 3 points
- Between 10% and 25% = 2 points
- Less than 10% = 1 point
- Unknown = 0 points

Number of Points Scored:

15. Approximately what percentage of your permanent supportive housing providers will accept applicants with the following characteristics:

a) Active Substance Use

- Over 75% = 5 points
- 75%-51% = 4 points
- 50%-26% = 3 points
- 25%-10% = 2 points
- Less than 10% = 1 points
- Unknown = 0 points

b) Chronic Substance Use Issues

- Over 75% = 5 points
- 75%-51% = 4 points
- 50%-26% = 3 points
- 25%-10% = 2 points
- Less than 10% = 1 points
- Unknown = 0 points

c) Untreated Mental Illness

- Over 75% = 5 points
- 75%-51% = 4 points
- 50%-26% = 3 points
- 25%-10% = 2 points
- Less than 10% = 1 points
- Unknown = 0 points

d) Young Adults (18-24)

- Over 75% = 5 points
- 75%-51% = 4 points
- 50%-26% = 3 points
- 25%-10% = 2 points
- Less than 10% = 1 points
- Unknown = 0 points

e) Criminal Background (any)

- Over 75% = 5 points
- 75%-51% = 4 points
- 50%-26% = 3 points
- 25%-10% = 2 points
- Less than 10% = 1 points
- Unknown = 0 points

f) Felony Conviction

- Over 75% = 5 points
- 75%-51% = 4 points
- 50%-26% = 3 points
- 25%-10% = 2 points
- Less than 10% = 1 points
- Unknown = 0 points

g) Sex Offender or Arson Conviction

- Over 75% = 5 points
- 75%-51% = 4 points
- 50%-26% = 3 points
- 25%-10% = 2 points
- Less than 10% = 1 points
- Unknown = 0 points

h) Poor Credit

- Over 75% = 5 points
- 75%-51% = 4 points
- 50%-26% = 3 points
- 25%-10% = 2 points
- Less than 10% = 1 points
- Unknown = 0 points

i) No Current Source of Income (pending SSI/DI)

- Over 75% = 5 points

- 75%-51% = 4 points
- 50%-26% = 3 points
- 25%-10% = 2 points
- Less than 10% = 1 points
- Unknown = 0 points

<u>Question Section</u>	<u># Points Scored</u>
Active Substance Use	
Chronic Substance Use Issues	
Untreated Mental Illness	
Young Adults (18-24)	
Criminal Background (any)	
Felony Conviction	
Sex Offender or Arson Conviction	
Poor Credit	
No Current Source of Income (pending SSI/DI)	
Total Points Scored in Question #17:	

To calculate your Housing First Score, add the total points scored for each question above, then refer to the key below:

Total Housing First Score:

If you scored: 77 points or more

- ✓ Housing First principles are likely being implemented ideally

If you scored between: 57 – 76 points

- ✓ Housing First principles are likely being well-implemented

If you scored between: 37 – 56 points

- ✓ Housing First principles are likely being fairly well-implemented

If you scored between: 10 – 36 points

- ✓ Housing First principles are likely being poorly implemented

If you scored under 10 points

- ✓ Housing First principles are likely not being implemented

Appendix 6:
Reentry/Recidivism
Studies

J Ambulatory Care Manage
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Facilitators and Barriers to Continuing Healthcare After Jail A Community-integrated Program

**Thomas Lincoln, MD; Sofia Kennedy, MPH;
 Robert Tutbill, PhD; Cheryl Roberts, MPA;
 Thomas J. Conklin, MD; Theodore M. Hammett, PhD**

Abstract: A cooperative, community-oriented “public health model of correctional healthcare” was developed to address the needs of persons temporarily displaced into jail from the community, and to improve the health and safety of the community. It emphasizes 5 key elements: early detection, effective treatment, education, prevention, and continuity of care. In the program, physicians and case managers are “dually based”—they work both at the jail and at community healthcare centers. This, together with discharge planning, promotes continuity of care for inmates with serious and chronic medical conditions. This report characterizes the health status and healthcare in this group, and identifies facilitators and barriers to engagement in primary medical and mental health care after release from jail. **Key words:** *case management, continuity of care, jail, prisons, reentry, urban health*

WITH the dramatic growth in jail and prison populations over the past 2 decades, the fields of correction and healthcare have come to realize the magnitude of chronic and infectious diseases and mental illness in correctional populations and the opportunity for public health intervention this presents (Glaser & Greifinger, 1993; Hammett et al., 2002). This is particularly so for jails,

where the number of individuals passing through and returning to the community is many-fold higher than in prisons. This population generally has limited access to healthcare when they are in the community and engage in risky behaviors at a higher rate than the general population. As a result, the need and potential exist to engage those incarcerated in medical care both in jail and after release to (1) diminish the progression and spread of disease; (2) improve public safety; (3) shift healthcare utilization from more expensive and reactive emergency department and hospital care to prevention, self-care, and primary care; and (4) facilitate successful reentry to society to the benefit of the individual, family, and community (Hammett, 2001; Miles & Lincoln, in press; National Commission on Correctional Healthcare and National Institute of Justice, 2002; Travis, 2005).

To address the needs of this seriously at risk population, the Hampden County Correctional Center (HCCC), 4 community health centers, and the Massachusetts Department of Public Health developed a cooperative, community-oriented “public health model of correctional healthcare” that emphasizes 5 key elements: early detection, effective

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treatment, education, prevention, and continuity of care (Conklin et al., 1998, 2002). The model promotes substantial continuity of care for inmates with serious and chronic medical conditions through physicians and case managers who are “dually based”—working both at the jail and at community health centers. The public health model philosophy recognizes that the jail is an integral part of the community, that those incarcerated are only temporarily displaced members of the community, and that incarceration presents an opportunity to benefit the health of these individuals, their families, and the communities to which they return.

The HCCC and Abt Associates Inc. undertook a multifaceted evaluation of the program. Here we attempt to characterize the health status of HCCC inmates with chronic physical and mental health conditions, and identify facilitators and barriers to engagement in primary medical and mental health care after release from jail.

PROGRAM DESCRIPTION

The HCCC is a medium-security facility that houses about 1800 pretrial and sentenced inmates serving a metropolitan area in western Massachusetts with a population of about 500,000. Roughly one third of inmates are released in 3 days or less, one third stay for 4–90 days, and a third for 91 days to 2¹/₂ years. About 75% of the jail population resides in 4 neighborhoods of the county—each of which has a community health center. Conversely, more than 1% of the populations of the health centers’ core neighborhoods is in the jail at any given time and 4% pass through annually.

The model as implemented at the HCCC includes these key relevant features:

1. *Health center/geographic team approach*: at admission, inmates with serious chronic medical conditions are assigned to 1 of 4 healthcare teams according to their residential zip code. Each team comprises 1–2 physicians, a primary nurse, a nurse practitioner, and a case manager (Table 1). The physicians and case managers are “dually based,”

with the majority of the physicians’ time in the community, and the case managers’ in jail. The primary nurse and nurse practitioner are based only in the jail. Ongoing care is scheduled with the primary nurse, nurse practitioner, or physician.

2. *Discharge planning*: Discharge planning and follow-up using the dually based healthcare providers promotes continuity of care.
3. *Community Partners*: The HCCC has contracted with local community health centers and mental health, dental, and optometry vendors to deliver services at the jail and in the community after release.
4. *Health education*: The HCCC offers robust inmate health education, including HIV and hepatitis peer education, substance abuse treatment, and disease management/self-care for patients with chronic disease.

The full model* (dually based provider teams, case management, discharge planning, and arrangement of postrelease appointments) is generally only available to inmates with serious or chronic medical conditions, although other inmates in need of short-term attention to medical issues receive components. In general, inmates with solely mental health problems do not receive services from the dually based provider teams. Rather, their postrelease mental health services are facilitated by referrals through a mental health discharge planner.

The discharge planning process for inmates with chronic medical and mental health conditions involves assessment, development of a discharge plan, referral to appropriate community resources, advocacy for clients, and scheduling and preparing for initial healthcare appointments post-release. It also often involves addressing the vocational,

*Extensive program descriptions, including the initial health assessments and ongoing healthcare programs at HCCC, are available from the authors and at www.mphaweb.org/hccc.

Table 1. Staffing model for public health model of correctional healthcare*

Provider	Population served	Staffing	
Physician (1-2 per team)	All inmates assigned to team	0.5-1 d per wk at the HCCC [†] 4 d per wk at the health center	
Primary nurse (1 FTE per team)	All inmates assigned to team	HCCC	} 4 teams serve inmates according to residential zip code
Nurse practitioner (0.5-1 FTE per team)	All inmates assigned to team	HCCC	
Case manager (1 FTE per team)	All HIV-positive inmates assigned to team Chronically ill inmates assigned to team (as needed/resources available)	3 d per wk at HCCC 2 d per wk at the health center	
Discharge planning nurse (1)	All inmates with chronic medical conditions	HCCC	} Discharge planners serve all inmates
Mental health discharge planner (1)	All inmates with mental health conditions	HCCC	

*Total HCCC medical staff: 4-8 physicians, 4 primary nurses, 2-4 nurse practitioners, 4 case managers.

[†]HCCC indicates Hampden County Correctional Center.

housing, and financial assistance needs of inmates, including applications for governmental support programs (eg, Medicaid, Social Security) and monitoring legal processes (eg, parole).

Case management follows the model developed in HIV care (New York State Department of Health AIDS Institute Medical Care Criteria Committee, 1997) with "skills and a knowledge base that encompasses sensitivity to the psychosocial issues of drug use, chronic illness, poverty and discrimination." (Indyk et al., 1993) Furthermore, in identifying staff for this type of program, "more weight is placed on the experience of case managers with populations affected by HIV than with academic or theoretical training in social case management" (Fleisher & Henrickson, 2000; Piette et al., 1992). HCCC case managers however serve both inmates with HIV and persons with other chronic medical conditions. Besides the latter group's obvious need for ser-

vices, another benefit is better maintenance of confidentiality of HIV status, often challenging in the fishbowl of corrections, where others might be able to observe which staff see which client. HIV-negative inmates are referred to case management according to need balanced with resources.

The discharge planning nurse (DPN) is jail-based but interacts with numerous community agencies including the courts, placement facilities, and medical providers, and all 4 jail healthcare teams. The DPN typically manages care for inmates with complex medical needs including those requiring placement in skilled nursing facilities and also serves as the health services department liaison with the HCCC security classification department.

Mental health services in-house are provided by a contracted nonprofit vendor. A jail-based mental health discharge planner meets with sentenced inmates several times in the 3-month period prior to release, and

with pretrial inmates as needed. Inmates are connected to a mental health provider in their community who is accustomed to working with the community health center, and a postrelease appointment is scheduled for motivated patients.

METHODS

To be eligible for the study, an inmate had to have (1) been admitted to the HCCC and reenter the community between April 5, 2000, and September 16, 2001; (2) a serious chronic medical (ie, one that would typically require chronic medication or at least 3 visits per year to a medical provider) or mental health (ie, Axis 1 diagnosis of schizophrenia, major depression, or bipolar, anxiety, or posttraumatic stress disorders) condition identified by health services staff; and (3) been in the community for more than 3 of the 6 months preceding incarceration. A total of 336 individuals were recruited into the study, and 200 of these were released to the community during the study period.

Data sources included participant interviews[†] and data from jail medical records and administrative files. The study protocol was reviewed and approved by the Institutional Review Board of Baystate Medical Center in Springfield, Mass.

The outcome measures reported in this article are

- patients' perceptions of and satisfaction with healthcare services in jail and in the community;
- barriers to and facilitators of obtaining healthcare in the community;
- the proportion of patients who attended a prescheduled community follow-up appointment or who saw other healthcare providers in the 30 days after release.

Other study outcome measures not reported in here include healthcare utilization after release (ie, hospitalization, emergency department) and self-reported health status.

Baseline interview

The baseline interview was conducted at the jail as close to admission as possible. The research interviewer explained the study and made clear the voluntary nature of participation. In a private setting, if written informed consent was given, then participants were interviewed individually. The necessary contact information was sent to Abt Associates in a secure transfer for follow-up in the community.

Follow-up interviews

Follow-up interviews were conducted at 30 days and 6 months after release. The window period for the 1-month interview was 3 to 5 weeks after the index release. The original window period for the 6-month interview was 5 to 8 months after the index release but was broadened in March 2001 so that participants could be contacted for the 6-month interview at any subsequent point until the study ended. Both follow-up interviews were conducted using computer-assisted telephone interviewing (CATI) technology. A variety of strategies were used to identify as many study participants in this difficult-to-reach population: a toll-free number, detailed locator information, mailings, and use of local "trackers." The "trackers" were equipped with cell phones, came from the same communities, and had connections to the area service providers. To avoid biasing the results, the research team did not use the dually based case managers to contact the participants.

Participants received incentives (a mall gift certificate) for completing the follow-up interviews and a prepaid phone card with the preinterview reminder letters.

Barriers to locating participants for follow-up interviews

We encountered many barriers to finding participants for postrelease interviews. After release, participants were often homeless or had unstable housing. Often participants did not have the resources to call in for the interviews. Drug and alcohol use sometimes made it hard to contact participants, or prevented us from being able to interview participants

[†]Instruments are available from the authors.

who were not sober when we reached them and then did not call back. Many study participants were reincarcerated. If the study team was informed that a participant was incarcerated at the HCCC, they would arrange an interview there. However, it was very difficult to set up the interview for inmates incarcerated at other facilities, and, even at the HCCC, inmates were frequently released or transferred before the interview could occur.

RESULTS

Approximately 30% of the inmates admitted to the HCCC during the recruitment period left the jail before the day 3 physical examination and therefore could not be recruited for the study. Over the study period, 576 individuals were referred to the study interviewers. Some refused to participate, a few were too sick or considered too dangerous to be interviewed, and some were missed at busy periods and discharged before they could be interviewed. Of those remaining, 336 had an appropriate condition and completed the baseline interview. Of those 336, 136 were not eligible for the follow-up interviews as some were not discharged directly back to the community, others remained incarcerated at the cut-off date, but, more commonly, many had not spent at least 3 of the 6 months prior to their index incarceration in the community. Ultimately, 200 of the inmates interviewed at baseline were eligible for follow-up in the community. Of them, 124 completed the 30-day interview and 131 completed the 6-month interview. Seventy-six of the 200 participants released to the community completed at least 1 of the follow-up interviews, while 52% completed both.

Comparison of the groups identified for study referral, interviewed at baseline, and eligible for study follow-up

Basic demographics (eg, sex, age, race/ethnicity, pretrial/sentenced status, length of incarceration, and health center team) were available on referred inmates who did not complete the baseline interview. Most variables were similar for those identified ($N =$

576), interviewed ($N = 336$), and eligible for study follow-up ($N = 200$), but several statistically significant differences among groups were found. A higher percentage of those interviewed than those identified were women because of the special effort to recruit females in the study. Those with short stays (less than 30 days) were less likely to agree to participate in the study, and those with the longest stays (more than 91 days) less likely to be eligible for study follow-up.

For all but a few of these variables, the inmates interviewed who were eligible and those ineligible for study follow-up were similar. The inmates eligible for follow-up tended to be somewhat more frequent users of medical and mental health care services and tended to engage more often in risky health behaviors.

Description of the group interviewed at baseline ($N = 336$)

Self-assessed health status

At baseline, 53% of respondents rated their health in the previous 30 days as poor or fair, 39% experienced moderate or severe physical pain, 34% had little or no help available to them from family or friends, and 61% were "quite a bit" or "extremely bothered" by emotional problems. For the 6-month period prior to incarceration, 40% reported physical limitations on usual activities and 41% reported limitations due to emotional or mental health problems.

Healthcare utilization

In the 6 months prior to incarceration, 69% of respondents had received medical care; 29% of these saw a doctor 3 or more times; 18% of respondents were admitted to the hospital, and 42% received care at an emergency department. Medicaid paid for 66% of respondents' last medical care visits.

Mental health care

Fifty-eight percent of the sample reported ever having been diagnosed with or treated for a mental health condition. Among this group, 65% received care in the 6 months prior to incarceration (47% of these had 7 or

more visits to mental health care providers), 26% had received overnight mental health care, and 29% went to the emergency department for a mental health problem. Medicaid paid for 87% of respondents' last mental health care visits.

Cigarette smoking

More than 81% of the respondents had smoked a cigarette (not including marijuana) in the 30 days before incarceration. Sixty-six percent of these smoked a pack or more a day and 76% wanted to quit smoking.

Alcohol consumption

In the 30 days prior to incarceration, 70% of respondents drank alcohol, with 61% drinking 3 or more days a week and 76% drinking 5 or more drinks at a time. Sixty-eight percent of current and former drinkers had participated in an Alcoholics Anonymous or other 12-step program for their own drinking problem and 32% had participated in an inpatient treatment program.

Street drug use

In the 30 days prior to incarceration, 44% of respondents smoked marijuana, 30% used crack cocaine, 25.3% used powdered cocaine, 35% used heroin, and 9% used another street drug. Thirty-four percent of respondents reported ever injecting drugs, 19% in the 30 days prior to incarceration, and 58% of drug injectors had shared needles.

Sexual behavior

In the 6 months prior to the interview, 32% of male respondents had 2 or more sex partners and 46% of these reported using a condom in the last 30 days. Some 65% of the sexually active had combined drinking or drugs with sex, 19% had sex with a member of the opposite sex that they did not know well, 59% discussed safe sex with a partner, 24% used a condom because a partner asked them to, and 44% convinced a partner to use a condom.

HIV testing

Seventy-seven percent of respondents had had an HIV test at some point in the past,

with 13% of them reporting a positive result. Among those who were not tested or tested negative, 52% felt they had no chance of getting infected, and 64% were less worried about HIV than other problems.

Violence

Physical violence was common in this group, with 28% reporting that they had ever hurt someone else and 29% reporting ever being hurt by someone else. Forty-five percent were physically hurt as a child by a caretaker, while 13% reported being sexually abused as a child.

Living situation

Prior to incarceration, 17% of the respondents were living alone and another 4% were homeless.

Education and employment

Essentially half of the respondents had completed less than a high school education, while 18% had additional education beyond high school. Only 39% reported having a full time job before incarceration.

Educational/training programs

There was considerable interest expressed in participation in the following programs either in jail or in the community: 45% were interested in HIV prevention, 42% in disease management, 50% in anger management, 54% in adult education, and 61% in job training. Regarding after-treatment incarceration programs, 42% were interested in smoking cessation programs and 64% in substance abuse treatment.

Description of the group eligible for postrelease interviews

Tables 2 and 3 present the qualifying chronic medical and mental health conditions of study participants, respectively.

Characteristics of respondents and nonrespondents to the follow-up interviews

A comparison of individuals who completed at least 1 follow-up interview and those

Table 2. Qualifying chronic medical conditions of study sample ($n = 200$)*

Medical condition	Number of participants with diagnosis	Percentage of baseline sample with diagnosis
Hepatitis C	51	26
Asthma	39	20
Hypertension	35	18
HIV/AIDS	19	10
Musculoskeletal	15	8
Diabetes mellitus	14	7
Gastrointestinal	13	7
Seizure disorder	10	5
Cardiovascular (except hypertension)	7	4
Other	13	7

*Total is greater than 162 because up to 2 diagnoses could be recorded per participant.

Table 3. Qualifying mental health conditions of study sample ($n = 200$)*

Mental health condition	Number of participants with diagnosis	Percentage of baseline sample with diagnosis
Depression	82	41
Bipolar disorder	16	8
Adjustment disorder	8	4
Anxiety disorder	6	3
Schizophrenia	5	3
Posttraumatic stress disorder	4	1
Psychosis	1	1

*Total is greater than 93 because up to 3 diagnoses could be recorded per participant.

who were lost to follow-up (ie, completed neither follow-up interview) was conducted on more than 200 characteristics, including demographics, length of jail stay, and baseline survey responses; there were several statistically significant differences. In the 6 months prior to incarceration, those lost to follow-up were more likely to have had 1 or more mental health visits ($P = .05$); more likely to have paid with their last medical ($P = .048$) or mental health ($P = .016$) care visit with Medicare; more likely to live alone or be homeless ($P = .003$); less likely to be employed full-time ($P = .054$); more likely to engage in riskier sexual behavior (have sex with a partner not well known) ($P = .01$); and more likely to have ever had an HIV test ($P = .007$).

Description of the group interviewed at follow-up

Housing, employment, and health insurance

Table 4 shows that 6 months after release, more than one quarter of respondents had experienced some form of housing instability, including spending one night sleeping on the street, staying in a shelter, or living in a supervised setting. Rates of unemployment were also very high in this group—62% were unemployed at the time of the 30-day interview and two thirds (67%) at the time of the 6-month interview. About three quarters (76%) of 30-day respondents also reported having some form of public or private health insurance.

Satisfaction with care at the HCCC

Thirty days after release, respondents rated the quality of the healthcare services that they received in jail and their satisfaction with the jail healthcare providers (Table 5). Six months after release, respondents rated the quality of the health and mental health care services they received in the community and their satisfaction with the community healthcare providers (Table 6). Open-ended questioning to elicit specific problems found the waiting time for services and the

Table 4. Housing and employment status at 30-d ($n = 124$) and 6-mo ($n = 131$) follow-up

Status	30 d postrelease	6 mo postrelease
Spent at least 1 night homeless, in a shelter or in a group/transitional residence during the follow-up period*	16 (13.0%)	34 (26.0%)
Spent at least 1 night sleeping in an abandoned building, a car, on the street, or in a park during the follow-up period	10 (8.1%)	21 (16.2%)
Spent at least 1 night in a shelter during the follow-up period	4 (3.3%)	18 (13.7%)
Spent at least 1 night in a group/transitional residence during the follow-up period	4 (3.3%)	11 (8.5%)
Reincarcerated during the follow-up period	- [†]	44 (33.6%)
Unemployed at the time of the interview	77 (62.1%)	89 (67.0%)

*Total represents unduplicated individuals, but respondents could select multiple categories.

[†]Data not available on reincarceration at 30 d.

treatments prescribed as the most common complaints—more frequently regarding in-jail care than community care.

Linkages with community-based healthcare at the 30-day follow-up

Table 7 summarizes key findings from the 30-day follow-up interview relating to linkages to and utilization of healthcare in the community. Just over half of inmates with a medical condition received an appointment with a community-based medical provider before they left the jail. Reported reasons for not keeping first appointments within the first month were scattered among such things as lacking transportation or childcare, scheduling conflicts, being too

ill, drug or alcohol problems, and simply forgetting.

Barriers to and facilitators of health-seeking behavior in the community at the 30-day follow-up

Tables 8 summarizes the responses regarding barriers to obtaining community-based care. Major factors considered by releasees to be very or somewhat helpful in their connecting with community-based care (Table 9) included having prerelease appointments (92% of those who received appointments), the healthcare provided in the jail (87%), health education received in the jail (82%), and having dually based providers (69%).

Table 5. Rating of quality of jail health services and trust in jail health staff ($n = 97$)

Rating	Poor	Fair	Good	Very good	Excellent
Quality of jail health services	15.5%	26.8%	16.5%	22.7%	18.6%
	None	Little	Some	A lot	Complete
Trust in jail health staff*	12.4%	12.4%	24.7%	32.0%	17.5%

*1 missing value.

Table 6. Rating of quality of community health ($n = 61$) and mental health ($n = 54$) services and trust in community health staff ($n = 61$)

Rating	Poor	Fair	Good	Very good	Excellent
Quality of community health services	3.3%	21.3%	27.9%	23.0%	24.6%
Quality of community mental health services*	11.1%	11.1%	37.0%	18.5%	13.0%
	None	Little	Some	A lot	Complete
Trust in community health staff†	3.2%	11.5%	23.0%	23.0%	36.1%

*5 missing values.

†2 missing values.

DISCUSSION

Health-related characteristics of the population

As might be expected given the eligibility criteria, study participants were in relatively poor physical and mental health, but also had surprisingly high levels of receipt of healthcare in the 6 months preincarceration (some of it perhaps during previous incarcerations) and relatively high rates of health insurance coverage. The most prevalent medical conditions were hepatitis C, asthma,

hypertension, and HIV/AIDS. The most prevalent mental health diagnoses were depression and bipolar disorder. Smoking, substance abuse, high-risk sexual practices, and violence (perpetration and victimization) were quite prevalent among participants.

Satisfaction with health services

Fifty-eight percent of respondents rated HCCC health services as "good" or better, with 77% giving these ratings to medical care in the community postrelease and 69% to community mental health care. Seventy-four

Table 7. Linkages with medical ($n = 97$) and mental health ($n = 56$) care in the community: selected results from 30-d follow-up interviews

	Physical conditions ($n = 97$)		Mental health conditions ($n = 56$)	
	<i>n</i>	%	<i>n</i>	%
Had a prerelease appointment made (% of total)	51*	53%	20	36%
Kept first appointment (% of those who had an appointment)†	33	65%	14	70%
Saw a provider/no appointment (% of total)	20	21%	19	34%
Total saw any provider (% of total)	53	55%	34	61%
Provided medications/prescription at release (% of total)	39	40%	25	45%

*1 missing value.

†Date for the medical appointment had not come up at the time of follow-up interview for 2 participants; these were excluded from the denominator.

Table 8. Barriers to seeking care in the community at 30-d follow-up ($n = 124$)

Barriers	A big problem	Somewhat of a problem	Not a problem	Not applicable
Not having transportation	51 (41%)	21 (17%)	48 (39%)	4 (3%)
Not being able to pay for care or medication	29 (23%)	18 (15%)	68 (55%)	9 (7%)
Not being able to get an appointment	25 (20%)	20 (16%)	73 (59%)	6 (5%)
Conflicts with work or other activities	18 (15%)	23 (19%)	78 (63%)	5 (4%)
Not liking the care you get from providers	11 (9%)	15 (12%)	88 (71%)	10 (8%)

percent reported having “some” or more trust in jail health staff, and 82% gave these ratings to community medical services. The jail and community responses however are from the different respondent groups at 1 and 6 months, respectively, and so cannot be directly compared.

Linkage with community-based health

Fifty-three percent of respondents with medical problems and 36% with mental health problems left the jail with an appointment to see a provider in the community. This was lower than the program goal, even though those who received appointments may have been those most in need of postrelease care and those most likely to receive it. Sixty-five percent kept their first medical and 70% their first mental health care appointments; 55% of those with medical and 61% of those with mental health problems either kept their first appointment or saw another provider in

the community without an appointment arranged at the HCCC. Because of a prior pattern of mental health patients failing to make appointments in the community, the mental health discharge planner’s practice was to only schedule appointments for those they considered most likely to show up, as seems to have been the case.

Overall, these results indicate that the Hampden County program was moderately successful in linking inmates to medical care in the community and that a majority of releasees do seek care in the community within 30 days of their release from the jail. As well, some did not require care within the first month and had later appointments.

Barriers and facilitators for follow-up

Transportation was the most common barrier to follow-up care in the first month. Even though housing instability and unemployment were not cited as major barriers,

Table 9. Facilitators to seeking care in the community at 30-d follow-up ($n = 124$)

Facilitators	Very helpful	Somewhat helpful	Not helpful	Not applicable
Postrelease medical appointment set up in advance	43 (35%)	5 (4%)	4 (3%)	72 (58%)
Healthcare in jail	53 (43%)	55 (44%)	14 (11%)	2 (2%)
Health education in jail	58 (47%)	43 (35%)	20 (16%)	3 (2%)
Dually based providers	57 (46%)	29 (23%)	19 (15%)	19 (15%)
Drug/alcohol treatment in jail	50 (40%)	30 (24%)	14 (11%)	30 (24%)

they were quite common among respondents and may partially explain why some study participants did not access healthcare after release.

The primary facilitators to seeking care in the community cited were having appointments scheduled, the health education provided in the jail, and having dually based providers. These continuity of care and linkage services provided by the Hampden County program were considered by patients to be very helpful in their accessing care in the community postrelease, and particularly salient is the high rate of perceived helpfulness attributed to having an appointment with a provider in the community.

Limitations

Limitations of the study included the relatively small sample size—significantly smaller than anticipated. As well, our sample was not fully representative of all newly admitted inmates with chronic conditions. First, inmates who left the facility before the medical examination on day 3 were not available for evaluation and recruitment into the study. Second, study recruitment efforts in the jail were not always consistent. Third, the study excluded inmates who did not spend at least 3 months in the community prior to the index jail admission and inmates who were not released directly to the community (40% of those ineligible).

When we compared demographic characteristics of the sample from the baseline survey, there were few differences other than length of stay between inmates who were identified with chronic conditions ($N = 576$), recruited into the study ($n = 336$), and released and eligible for follow-up ($n = 200$). However, inmates eligible for follow-up tended to be higher users of medical care (primary and urgent) and mental health care than the total group recruited into the study at baseline. Respondents and nonrespondents of the postrelease interviews were generally similar according to measured characteristics. Nonetheless, there remains a high probability that the issues and rates of follow-up differed in the nonrespondents. While not unan-

anticipated, one quarter of the group referred had no follow-up information available.

Also important, a higher than expected proportion of patients with less intensive chronic conditions enrolled in the study (eg, individuals with hepatitis C, hypertension, and mild asthma). Conversely, some of the more intensive chronic conditions, such as HIV, were underrepresented in the study. HIV-positive inmates tend to be an older group with more injection drug addiction and prior charges, and are often incarcerated longer, thus excluding them from the study at higher rates.

The HCCC encountered some challenges during the study period in administering program services consistently with fewer services received by inmates than expected. We found that a large proportion of study participants did not participate in key measured components of the program. In addition, data on services actually received were sometimes incomplete.

Continuity of care

Discharge planning, community linkages, and continuity of care in jails and even prisons in the United States remain inadequate (Hammett et al., 2001; King & Chavez, 2004). Of the 31 respondents out of 50 state correctional medical officers surveyed, only 19 actually scheduled postrelease healthcare (Flanagan, 2004). A survey of prisons with capacities of more than 1000 found that only one quarter of prisons offer prescriptions, and one third offer a 14- or 30-day supply of medication for reentry (Veysey & Schacht, 2001). Complicating this further, challenges to healthcare continuity upon reentry such as decreased access to health insurance, the diminished role of the public sector in healthcare, and further erosion of the safety net are worsening (Freudenberg 2004).

Against this background though, there have been various innovative programs addressing some of the challenges and promoting continuity of care. Notable features of these programs include the following:

1. Case management: various models are being used. Issues addressed are not

limited to medical care ("Michigan DOC," 1999; Conklin et al., 2002; Council of State Governments, 2004; Ehrmann, 2002; Freudenberg, 2004; Rich et al., 2001; Veysey et al., 1997). For substance-abusing arrestees, case management was associated with more access to drug treatment and less crimes committed than a control group who received only referrals or a single counseling session (Rhodes & Gross, 1997). Postrelease maternity case management was associated with decreased odds of low birth weight (Bell et al., 2004). Women who participated in postrelease services including case management were significantly less likely to be rearrested in the year after release than a comparable group of women who participated in jail services but were not eligible for postrelease services (Freudenberg et al., 1998).

2. Development of a personal connection with the client before release (Myers et al., 2003).
3. Dually based healthcare workers who work with patients/clients both in the corrections program and the community: this not only promotes a personal connection, but bridges programs, brings community perspective into the correctional institution, and vice versa. In Rhode Island, the HIV program physicians and nurses meet and care for patients in the correctional facility and continue their relationship into the community (Rich et al., 2001). In the same program, women at high risk for HIV and reincarceration demonstrated lower recidivism rates than a historical control group (Vigilante et al., 1999). In 4 urban centers, continuity of medical care by a single healthcare provider was associated with decreased likelihood of incarceration in women (Sheu et al., 2002). For persons with chronic medical conditions at the HCCC, increased services in jail predicted increased follow-up for primary care (Kennedy et al., 2003). Besides

providing continuity of care at reentry, this model also often provides continuity of care at incarceration (Conklin et al., 1998, 2002; Council of State Governments, 2004).

4. As is said in the hospital, "discharge planning begins at admission" such that care continues after release. This is particularly important for jails given the shorter stays and unexpected releases. That being said, in many programs, some of the major components of discharge planning activity are suitably triggered to start at some number of months or such prior to release.
5. Appointments scheduled for follow-up healthcare in the community: as found here, this basic step was rated as very helpful by patients with chronic health conditions released from one jail, may serve as a marker of a tangible discharge plan, and was found to be a leading predictor of follow-up (Hammett et al., 1999; Kennedy et al., 2003). In the Cook County, Ill, program, which included some dually based care providers, the follow-up rate was 60% for patients scheduled with the HIV Core Center program ("Jails in unique position," 2004).
6. A summary record of important health conditions, medications, allergies, and diagnostic studies, vaccinations, and other important treatments for each person released to be available to the community health provider at or prior to the time of first visit. Electronic transfer between compatible systems is an active goal. In San Francisco, a single uniform electronic medical record between the jail system and community sites is in progress (King & Chavez, 2004). A significant developing mechanism is the "Continuity of Care Record"—a standard specification being created by a coalition of (inter)national organizations to improve portability of patient information and enable a provider to easily access a patient's most relevant and timely information at the beginning of the first

- encounter and easily update it for when care shifts to another provider, and help to bridge the gaps between electronic health record systems (Continuity of Care Record FAQs, 2003).
7. Medical benefits at release: given the critical nature of the first days and weeks postrelease, avoiding gaps in services is important, and having necessary benefits available promptly on release is key, not just for medical care and medications of course, but for other requirements such as food, housing, and transportation. Although effective arrangements have been possible to be set up between local welfare offices and individual institutions (with benefits “denied” on application from the correctional institution but maintaining the application in the system to allow activation once released) (Conklin et al., 2002; Savitz, 2002), legislation creates more widespread, dependable solutions. Recently, the Centers for Medicare & Medicaid Services sent a letter “Ending Chronic Homelessness” to state Medicaid directors on “assisting people leaving psychiatric facilities and correctional facilities to obtain Medicaid quickly,” and “encouraging states with this letter to ‘suspend’ and not ‘terminate’ Medicaid benefits while a person is in a public institution. . . Individuals who meet the requirements for eligibility for Medicaid may be enrolled in the program before, during, and after the time in which they are held involuntarily in secure custody of a public institution” (Stanton, 2004). Many states are improving this process. For instance, in Maryland, incarcerated Medicaid participants are maintained on the enrollment list, even if the person has been incarcerated for more than 30 days. Maryland notes the incarceration in its information system to prevent claims payment, but allows the person to immediately obtain Medicaid services once informed of the person’s release. For inmates who were on Medicaid before incarceration, the case manager helps them resume benefits (Eiken & Galantowicz, 2004).
 8. Geographic proximity maximization: the HCCC program provides a logical means for reentry transition services for prisons as state prisoners planning to return to live in Hampden County may be transferred to serve the last 6 months of their sentence at the HCCC. The same practice is expanding in Virginia, where partnerships with local jails and the state department of corrections allow selected prisoners to relocate from prison to a local jail in their community to receive transitioning services such as life skills workshops and assistance with housing and employment. (Re-Entry Policy Council, 2004; Virginia Department of Corrections, 2003) Efforts at a higher level of resolution (finer grain) are underway in Hampden County, Chicago, and other sites using geographical mapping methods to improve the success of referral and collaborations with community organizations by minimizing the barriers of distance and transportation.
- A number of other model practices to support reentry outside of healthcare have direct implications for correctional healthcare practice and organization. These include transitional programs with the sites of reentry from prisons, jails, and community corrections—much more than could be covered here. The recent Report of the Re-Entry Policy Council provides policy statements, recommendations, and considerable supportive material both on healthcare’s role in reentry, as well as more general social policies that are relevant and instructive to healthcare (Council of State Governments, 2004). As in the health aspects of reentry, much work remains to be done in other spheres. A couple of initiatives serve to illustrate process improvement efforts:
- The National Institute of Corrections’ Transition from Prison to Community Initiative (TCPI), is intended to help states improve their transition processes, with the overarching goals for released offenders to remain arrest-free over the long haul, and to

become competent and self-sufficient members of their communities (Barnett & Parent, 2002).

A successful mental health initiative, the Maryland Community Criminal Justice Treatment Program requires participating jurisdictions to develop an advisory board that includes representatives of organizations that serve ex-offenders in the community, such as mental health, alcohol and drug abuse, public defender, judicial, parole and probation, law enforcement, social service, and consumer and advocacy agencies. To receive funding, each advisory board must develop a memorandum of agreement that defines the specific services each agency will provide. For adults who have a serious mental illness,

and may also have co-occurring disorders, the state provides funds for case management and psychiatric services that begin in the correctional system, and an array of services through a managed care fee-for-service system (Hills et al., 2004).

CONCLUSIONS

Integrated jail and community healthcare is feasible. Further study of this and other initiatives in various locales is warranted. Several obvious barriers to care should be anticipated and addressed. Connecting patients to health services through a program that "spans the fence" is valued and facilitates continued primary and mental health care.

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RESEARCH REPORT

Evaluation of the Allegheny County Jail Collaborative Reentry Programs

Findings and Recommendations

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ABOUT THE URBAN INSTITUTE

The nonprofit Urban Institute is dedicated to elevating the debate on social and economic policy. For nearly five decades, Urban scholars have conducted research and offered evidence-based solutions that improve lives and strengthen communities across a rapidly urbanizing world. Their objective research helps expand opportunities for all, reduce hardship among the most vulnerable, and strengthen the effectiveness of the public sector.

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Executive Summary

In 2010 and 2011, Allegheny County, Pennsylvania, launched local reentry programs under the auspices of the Bureau of Justice Assistance Second Chance Act Adult Offender Reentry Demonstration Programs initiative. Designed to reduce recidivism and improve inmates' transition to the community, the first of these two programs (Reentry1) linked sentenced Allegheny County jail inmates to Reentry Specialists who coordinated reentry services and programming both in jail and the community. The second program (Reentry2) connected inmates to designated reentry Probation Officers before release, who then engaged offenders in prerelease reentry planning and supervised them in the community after release. Both programs attempted to reduce reoffending through the use of risk/needs assessment, coordinated reentry planning, and delivery of evidence-based programs and practices.

In September 2012, researchers in the Urban Institute's Justice Policy Center (Urban-JPC) initiated a 12-month process and outcome evaluation of both reentry programs to answer critical questions about program performance and effectiveness. The study's process evaluation examined program fidelity and alignment with core correctional practices. The outcome evaluation drew on administrative data to measure criminal justice outcomes, specifically rearrest, for reentry program participants and two comparison groups of offenders identified through propensity score matching techniques ($N=798$). The study was funded by the Allegheny County Jail Collaborative (ACJC), the county's reentry taskforce, with the support of local foundation resources.

Evaluation Strategy

ACJC stakeholders were eager for actionable information on program performance and commissioned the current study for that reason. With this in mind, and given the programmatic changes that had already been made or were underway at the time of the evaluation, Urban-JPC researchers focused on analyses that could inform program refinements, while also gathering and examining evidence of program effectiveness. An action research approach¹ guided evaluation activities and featured frequent feedback loops to supply stakeholders with needed information.

The evaluation approach featured two key components: a fidelity assessment and an impact analysis:

- The **fidelity assessment** examined the extent to which the ACJC’s reentry programs were implemented and operating as intended; identified factors associated with successful program implementation, potential barriers inhibiting program performance, and lessons learned; and assessed the programs’ alignment with core correctional practices. The assessment’s ultimate aim was to inform ACJC decisions about potential program modifications and additional program planning. Data sources included more than 40 semi-structured interviews with approximately 60 ACJC stakeholders, including program staff and partners; seven client and family member focus groups; and analysis of individual-level program data and administrative records ($N= 316$), including review of 76 case files.
- The **impact evaluation** focused primarily on *recidivism* results, as measured by *new arrests* and *new probation violations*. Because Reentry1 and Reentry2 had significant structural and philosophical differences in program logic and operations (Reentry1 was voluntary, while participation in Reentry2 was a mandatory condition of post-release supervision; case management services also differed between the programs), the study *analyzed the impact of each program independently* rather than pooling the data. A treatment group for each reentry program and a matched, weighted comparison sample were drawn from the administrative records using propensity score matching techniques. A comparison between these groups and the Reentry1 and Reentry2 program groups was used to determine the reentry programs’ effects on rearrest and probation compliance. A total of 798 cases were analyzed for the study: 215 Reentry1 cases and 189 comparison cases; 249 Reentry2 cases and 145 comparison cases. Data were drawn from three sources: the Adult Probation Case Management System, the Common Pleas Case Management System, and the Reentry1 program database.

Key Findings

Impact analyses, while limited, suggest that both Reentry1 and Reentry2 reduce rearrest among participants and prolong time to rearrest, particularly after the first 90 days post-release, indicating that initial and continued program efforts to stabilize clients are effective. Specifically, analyses indicated that reentry program participation reduces the probability of rearrest by 24 percentage points for those involved in Reentry1 (i.e., the Reentry1 group had a 10 percent probability of rearrest

while the comparison group had a 34 percent probability); this finding was statistically significant. Likewise, Reentry2 participants were less likely to be rearrested than the comparison group, however, this finding only approached statistical significance ($p = 0.056$). Program participation had little effect on supervision violations for the Reentry2 group. The programs' impact on reconviction and returns to custody could not be measured.

Findings of program impact on rearrest are supported by ample evidence of implementation fidelity and practices aligned with principles of effective intervention (Domurat et al. 2010; Matthews et al. 2001). For example, both programs consistently targeted offenders at medium- to high-risk for reoffending: case file review indicates that 92 percent of Reentry1 cases and 95 percent of Reentry2 cases reviewed scored as medium- to high-risk for recidivism. Additionally, 97 percent of Reentry1 cases had recorded risk/needs assessments and 100 percent of those cases with recorded assessments also had required Phase 1 reentry plans; 63 percent of those cases eligible to have both Phase 1 and 2 case plans, did so. In turn, 86 percent of the Reentry2 cases reviewed had recorded LSI-R risk/needs assessments; Offender Supervision Plans were common in the Reentry2 case files.

While needs-matching was more challenging to reliably assess, in part because of the structure and content of program case files, the available data indicate widespread use of designated programs and services. Importantly, cognitive behavioral intervention was found to be a core program component: nearly 68 percent of Reentry1 program participants received *Thinking for a Change*. Existing research supports the centrality of cognitive behavioral interventions to recidivism reduction (see, for example, Lipsey et al. 2007).

Both program models emphasize prerelease contact between inmates and key supports—Reentry Specialists (Reentry1) and designated POs (Reentry1 and Reentry2)—and the fidelity assessment found high compliance with these aspects of the model in both programs. These contacts were easier to systematically measure and substantiate for Reentry2. Under Reentry2, 84 percent of cases met with their designated POs before release (range spanned 1 to 8 contacts) and 75 percent had multiple contacts (2 to 14) in the community post-release.

Lastly, clients typically held positive views of the both the Reentry1 and Reentry2 programs. Reentry1 tended to receive higher marks, perhaps because of the program's intensive case management services. Reentry1 clients held their Reentry Specialists in high regard, and both groups viewed the program's emphasis on prerelease contact between clients and probation officers as helpful for reentry preparation. Clients in both programs reported access to and receipt of a wide range of services. Family support services, including the Reentry1 program's coached contacts with family

members and structured contact visits between inmates and their children, were among the program components most valued by clients. Clients noted a lack of housing resources, and encouraged program leaders both to offer more career-oriented employment options (apprenticeships) and to consider how to involve program alumni in peer support activities. Both Reentry1 and Reentry2 clients were eager to serve in a peer mentoring capacity; some viewed this as critical to their own continued rehabilitation, while others simply wanted to encourage new participants in their reentry processes.

Summary

There is strong and credible evidence that Allegheny County's Second Chance Act reentry programs reduce recidivism as measured by rearrest. Findings of program impact are coupled with ample evidence of strong program implementation fidelity and adherence to principles of effective intervention for criminal justice populations. Several recommendations in support of ongoing program improvement and strengthening are provided in the full report.

Section I. Introduction

In 2010 and 2011, Allegheny County, Pennsylvania, criminal justice and human services stakeholders partnered to launch two local reentry programs under the auspices of the Bureau of Justice Assistance (BJA) Second Chance Act (SCA) Adult Offender Reentry Demonstration Programs grants initiative. Designed to reduce recidivism and improve inmates' transition to the community, the first of these two programs (Reentry1) linked sentenced Allegheny County Jail (ACJ) inmates to a Reentry Specialist who coordinated reentry services and programming both in jail and the community, and a Family Support Specialist who worked with inmates and their families to prepare both parties for the inmate's release. The second program (Reentry2) connected inmates to one of five designated reentry probation officers prior to release, who then engaged offenders in jail-based services and prerelease planning, and then supervised them in the community after release. Both programs targeted offenders at moderate to high risk of reoffending and attempted to reduce the likelihood of recidivism through the use of objective risk/needs assessment, coordinated reentry planning, and delivery of evidence-based programs and services.

In September 2012, researchers in the Urban Institute's Justice Policy Center (Urban-JPC) initiated a 12-month² process and outcome evaluation of both SCA programs to answer critical questions about program performance and effectiveness. The study's process evaluation examined program fidelity and alignment with core correctional practices. The outcome evaluation drew on administrative data to measure criminal justice outcomes, specifically rearrest, for reentry program participants and two comparison groups of offenders identified through propensity score matching techniques (total $N= 798$). The study was funded by the Allegheny County Jail Collaborative (ACJC), the county's reentry task force equivalent,³ with the support of local foundations.

This report summarizes the study's findings, initially presented to the ACJC and its funders on February 11, 2014, and sets them in the context of extant research on reentry and evidence-based correctional practices. As such, this report begins with a review of reentry efforts in Allegheny County, including the Reentry1 and Reentry2 programs, and then briefly consults the research literature on reentry to set the current study and its results in context. Next, we discuss the study's objectives, methods, key evaluation components, and core evaluation activities. Results from the fidelity assessment are then presented, followed by the impact analysis and its findings. The report concludes by offering a series of actionable recommendations for research, practice, and programming drawn from the study's findings.

Reentry in Allegheny County

Allegheny County's efforts in prisoner reentry are both extensive and longstanding. Dating to 1997, Allegheny County was one of the first jail systems in the nation to develop holistic programs and services designed to support the successful reentry of exiting jail inmates through its establishment of the Allegheny County Jail Collaborative (Yamatani 2008). Allegheny County has also demonstrated a strong commitment to evaluation, commissioning the 2008 evaluation of the ACJC's efforts to inform programmatic changes and improvements.

Following Yamatani's 2008 study, the ACJC issued a three-year, three-pronged strategic plan for reentry and recidivism reduction in 2010 focused on (1) designing and implementing a new reentry program, (2) systems change, and (3) developing alternatives to incarceration (ACJC 2011). Several critical accomplishments followed in the first year of the plan's implementation, many within the Allegheny County Jail and with the support of the courts and other criminal justice system partners. These included: creating a staffed, after-hours informational phone line for family and friends of the incarcerated; working with the courts to make release more predictable by establishing a 48-hour minimum window for release notification; and implementing a "discharge center" within the jail to ensure that inmates were released with weather-appropriate clothing, medication as needed, resource information, accurate telephone contacts for key family members, and transportation as needed (ACJC 2011; 2012). Ostensibly, receipt of SCA funds facilitated significant expansion of prerelease programming in the jail. According to the ACJC 2011 Annual Report, twice as many inmates received services in the jail in 2011 as in prior years (ACJC 2011), while the scope of programming also expanded significantly. In 2010 and 2011, the ACJC and its partner, Allegheny County Adult Probation and Parole (Adult Probation), each secured funding from BJA under the SCA grant program to implement a more coordinated reentry strategy targeting inmates sentenced to and releasing from the ACJ, resulting in the Reentry1 and Reentry2 programs. These programs and their respective approaches to reducing recidivism are described below.

Reentry1

Established in 2010, the ACJC Reentry1 program provided qualifying ACJ inmates with five or more months of in-jail programming and services (Phase 1) to ready inmates for release, followed by up to 12 months of supportive services in the community (Phase 2). The program served both adult male and female inmates sentenced to a minimum of six months in the ACJ, who were returning to the county

upon release, and who scored as medium-to high-risk for reoffending on the three-question Proxy Triage Risk Screener⁴ (score of 5–8; commonly referred to as the Proxy). The program excluded individuals with pending charges, as well as those with technical and out-of-county holds, probation or parole detainers, and state or federal supervision requirements (Allegheny County Reentry Program Manual 2012). Core program elements included risk and needs assessment, service planning with treatment and programming in the jail, discharge planning, and intensive case management support post-release. There was also a family support component designed to facilitate healthy parent-child interactions prerelease through parenting classes and structured inmate-child contacts in jail and stable, sustainable relationships post-release. The program was a partnership between the ACJ, the Allegheny County Department of Human Services (DHS) and its division of Justice Related Services (JRS), Adult Probation, the Allegheny County Department of Health, Allegheny Correctional Health Services and numerous community-based providers, including:

- Allegheny Intermediate Unit (GED preparation and testing; pre-apprenticeship training)
- Amachi (mentoring for children of the incarcerated; structured prosocial activities)
- Family Services of Western Pennsylvania (family therapy and support)
- Goodwill Industries (employment and housing resources)
- Mercy Behavioral Health (counseling and cognitive behavioral therapy)
- Renewal Inc., ACTA/The Program and Goodwill (residential drug treatment; alternative housing)
- Springboard Kitchens (culinary arts apprenticeship program)
- Urban League (job readiness and life skills)

The Reentry1 program seeks to enhance reentry success and reduce the likelihood of recidivism by:

- **Identifying and reducing the risk of recidivism** through the use of a structured risk/needs assessment to guide Phase 1 service planning; referral to *Thinking for a Change* (T4C), a cognitive restructuring program offered both in the jail and in the community; and transfer to the jail's Reentry Pod—a structured housing unit located on the same floor as the jail's Reentry Center (to facilitate greater access to services and program staff) and designed to reinforce the cognitive behavioral principles of the Reentry1 program.
- **Coordinating pre- and post-release service provision** to address offender risks and needs through the assistance and support of dedicated Reentry Specialists (case managers). Reentry Specialists work with inmates in the jail to facilitate enrollment in and completion of targeted

interventions and services; they also design and implement discharge and transition plans that include basic supports and services for participants up to 12 months post-release.

- **Improving education outcomes** through the provision of literacy classes, adult basic education, peer tutoring, and pre-apprenticeship training through Allegheny Intermediate Unit, as well as GED classes pre- and post-release. Enhanced educational capabilities are foundational to strong employment outcomes.
- **Improving employment outcomes** through a tiered programming approach that often begins with the Urban League’s Reentry Assistance Management Program (RAMP), a 22-hour job readiness program provided to both currently and formerly incarcerated men and women. RAMP uses validated assessments, including the Holland Interest Survey, to identify and match inmate interests and skills to job options, and the pre-post Offender Reintegration Scale (ORS) to measure progress. Classroom instruction focused on communication and problem-solving skills, as well as job searches and employer expectations. Inmates are coached on how to broach their criminal histories with potential employers and receive instruction on how to obtain copies of their criminal records and how to have eligible offenses expunged. RAMP participants are frequently referred to Goodwill Industries’ vocational skills program, which focused on skills training and development and was designed to support and build upon the information provided to clients during the course of RAMP training and links. Goodwill case managers enrolled clients in CareerLink, the state-wide job database, trained them in the use of this service, and linked inmates to Goodwill’s job developers and employment outreach services. Goodwill frequently referred inmates to Springboard Kitchens, an intensive, hands-on culinary arts apprenticeship program that works with offenders post-release and places many graduates in positions.
- **Reducing substance abuse** through cognitive-based, gender-specific treatment and relapse prevention programs operated prerelease by Allegheny Correctional Health Services. Based on Seeking Safety, the Addiction and Trauma group reportedly focuses on female inmates, while the Family-Based Substance Abuse Program, which draws on cognitive behavioral therapy and motivational enhancement strategies to provide clients with relapse prevention skills and opportunities to increase motivation and commitment to recovery goals, focuses on male inmates. The latter uses a “family systems model” to expose participants to the effect of addiction on families and their roles as recovering parents.

- **Enhancing housing opportunities and housing stability post-release** through the assistance a client's Reentry Specialist and access to Goodwill's HARBOR Project, a 40-unit Housing and Urban Development-sponsored resource that provides eligible ex-offenders (sex offenders and arsonists are excluded) with housing and supportive services. Clients typically stay for six to nine months, although they may remain as long as two years. Housing could also be obtained through any of three homeless shelters and several recovery homes.
- **Supporting healthy family functioning and relationships** through parenting classes (*Inside Out Dads, 24/7 Dads, Moving On*), relationship classes, structured contact visits between inmates and their children, and the assistance of a dedicated Family Support Specialist who helped inmates reconnect with family and significant others through coached contacts (phone) prerelease that address roles, responsibilities, and expectations.
- **Increased compliance with post-release supervision orders** through the Program's dedicated reentry Probation Officer (PO) who conducted additional risk/needs assessments using the Level of Service Inventory-Revised (LSI-R) before release to inform post-release supervision and Offender Supervision Plans (OSPs); worked to ensure appropriate housing is in place for inmates post-release; and provided both clients and their supervising POs with critical information, including the date and location of the first post-release meetings (inmates) and Offender Supervision Plans (supervising POs).

A five-person team consisting of a designated Reentry Probation Officer and four Reentry Specialists works with eligible inmates prerelease to assess needs and link program participants to appropriate prerelease services and programming available through the jail's Reentry Center. Reentry1 inmates may also transfer to the jail's Reentry Pod (opened June 2012)—a structured living environment designed to reinforce the behavioral change elements of reentry programming and to facilitate access to reentry services and “in-reach” with community-based support staff. Additionally, the Reentry1 program works with inmates transferred to alternative housing; while technically in the community, these individuals were considered to be in custody and thus in Phase 1 of the Reentry1 program until the creation of their Phase 2 service plans.

Jail staff identified eligible inmates and would invite them to attend a program orientation⁵ during which the terms of program participation, including sanctions and incentives, were explained. Participation was voluntary, and inmates could decline to enter the program at this time. Most inmates reportedly chose to enroll. Those who chose to enroll then completed and signed an enrollment form,

which listed the Reentry1 program’s sanctions and rewards and identified social supports and anticipated post-release residence. Releases of information were also signed at this time.

Once enrolled, participants’ risks and needs were assessed using the Montgomery County risk/needs assessment (MoCo). Following assessment, the client’s Reentry Team—designated Reentry Specialist, Reentry PO, and Family Support Specialist—would meet with the client to review the assessment results and develop a Phase 1 plan, including referrals to the jail’s reentry programming and services and reentry goals. When possible, the client’s Reentry Specialist and/or Family Support Specialist would reach out to the inmate’s family members to secure their input regarding client needs or issues of concern relevant to development of the Phase 1 plan; ideally, Reentry1 program staff connected with family members before the Phase 1 team meeting.

Phase 2 began between 30 and 60 days before the inmate’s release and involved assessment with the LSI-R conducted by the Reentry PO, and development of a transition plan including a home plan. The LSI-R also informed post-release service provision. At this time, the Reentry1 PO would conduct a “home visit” to verify and solidify the inmate’s post-release housing arrangements. If the PO found the housing to be unacceptable or infeasible, the Reentry Specialist would work to secure appropriate housing.

Core Phase 1 (prerelease) and Phase 2 (largely post-release) program components are discussed below.

PRERELEASE CORE COMPONENTS

Screening and assessment, program orientation, service coordination and case management via the program’s Reentry Team, and family support services comprise the Reentry1 program’s core prerelease components. Service coordination, case management and family support continue in the community post-release. Prerelease, Reentry Specialists work with Reentry1 participants to implement the individualized Phase 1 service plans developed by participants and their Reentry Teams following assessment and program entry. Reentry Specialists maintain regular contact with clients in the jail, ideally meeting with clients at least twice a month to monitor participation and progress in designated reentry services and to address emerging needs or issues. Phase 1 plans may be modified depending on client needs.

Phase 2 reentry planning typically begins before release, and thus is a key prerelease program component.

POST-RELEASE CORE COMPONENTS

Reentry1 participants receive up to 12 months of services post-release, including intensive case management and support, assistance with basic needs (obtaining IDs, food, and clothing; benefits eligibility; and assistance with prescriptions), transportation (bus passes and actual transportation courtesy of Reentry Specialists), housing assistance, linkages to job readiness and apprenticeship programs, continuing cognitive behavioral therapy groups, substance abuse and mental health treatment, parenting classes, and referrals for other services. Reuniting clients with family members or their children is also a component of the program, facilitated primarily by a Family Support Specialist specifically tasked with supporting Reentry1 clients.

IMPLEMENTATION

A total of 341 individuals had been served by Reentry1 as of February 19, 2013, the date program data were accessed for this evaluation. Of this number, 25 were declared ineligible⁶ after program intake leaving 316 cases (287 men and 29 women) for analysis. Program enrollments spanned June 22, 2010, to February 8, 2013, indicating an average enrollment of nine cases per month. The first participant exited the program on September 21, 2010, when the client withdrew. A little over half ($N= 171$ or approximately 54 percent) of the cases available for analysis were closed: 56 percent ($N= 95$) constituted successful program completers, while the remaining 44 percent ($N= 76$) were closed for a variety of other reasons. Notably, 30 percent ($N= 23$) withdrew from the program. One-quarter ($N= 19$) were closed due to reincarceration, presumably within the state, while 15 percent ($N= 11$) failed to meet program requirements for participation.⁷ Just 5 percent ($N= 4$) were closed because of lack of engagement.

Participants logged 458 days or roughly 15 months in the Reentry1 program, on average. Those who successfully completed the program spent an average of 590 days or 19 months in the program. In either case, the average duration in Phase 1 was a little more than six months; clients spent about 12 months (359 days) in Phase 2. Both averages are consistent with the program model.

Although the structure of the Reentry1 program model remained largely unchanged, several modifications were made before and during the evaluation period. Figure 1 illustrates several of these changes (denoted by the bold font) by presenting the program's key components as implemented upon receipt of SCA grant funds in fall 2010, during the evaluation's data collection period (roughly September 2012 to August 2013), and proposed changes (subsequently implemented in fall 2013) as the current evaluation concluded. Modifications planned and implemented *after* the study's

observational period concluded in August 2013 (noted in the rightmost column of figure 1) are discussed later in this report (see section 6, Recommendations and Action Steps).

FIGURE 1

Reentry1 Program Overview

6/2010–8/2012	9/2012–8/2013 (study period)	Proposed 9/2013
<p><u>Prerelease (> 6 mos.)</u></p> <ul style="list-style-type: none"> ■ Proxy screening (L,M,H) ■ Reentry1 Orientation ■ MoCo Risk/Needs assessment ■ Phase 1 service plan ■ Reentry Specialists (RS) case management ■ Dedicated Family Support Specialist (FSS) ■ Dedicated PO liaison ■ Reentry services T4C, parenting classes, coached contacts/visits, job readiness and vocational education, marriage curriculum (Why Knot) <p><u>Transition Planning</u></p> <ul style="list-style-type: none"> ■ Phase 2 case conference and service plan; PO verifies home plan <p><u>Post-release (up to 12 mos.)</u></p> <ul style="list-style-type: none"> ■ RS case management; family support; other services ■ Probation opens second Day Reporting Center (DRC) 	<p><u>Prerelease (> 5 mos.)</u></p> <ul style="list-style-type: none"> ■ Proxy screening (M and H) ■ Reentry1 Orientation ■ MoCo Risk/Needs assessment ■ Phase 1 service plan ■ JRS RS case management. <p>Significant turnover</p> <ul style="list-style-type: none"> ■ Dedicated FSS <p>Lost 11/2012, not filled</p> <ul style="list-style-type: none"> ■ Dedicated PO liaison ■ Reentry services <ul style="list-style-type: none"> » T4C, parenting, coached contacts, contact visits, job readiness and apprenticeships, education; canceled Why Knot (replaced with relationship curriculum) <ul style="list-style-type: none"> ■ Reentry Pod opened <p><u>Transition Planning</u></p> <ul style="list-style-type: none"> ■ Phase 2 case conference and service plan; PO verifies home plan <p><u>Post-release (up to 12 mos.)</u></p> <ul style="list-style-type: none"> ■ RS case management; family support; other services; ■ Probation begins Reentry2 	<p><u>Prerelease (3–5 mos.)</u></p> <ul style="list-style-type: none"> ■ Universal Proxy screening ■ MoCo R/N assessment ■ AC Jail Reentry Admin. oversees prerelease reentry services ■ 2 AC Jail Reentry Coordinators ■ FSS via FSWP ■ Dedicated POs ■ Reentry services <ul style="list-style-type: none"> » T4C and Career Tech priority programs, parenting, family support, education, etc. ■ Community Service Coordinators (CSCs) through FSWP, perform family support <p><u>Transition Planning</u></p> <ul style="list-style-type: none"> ■ Clients and CSCs connect 60 days before release for transition planning <p><u>Post-release (up to 9 mos.)</u></p> <ul style="list-style-type: none"> ■ Coordinated CSC-PO teams work with clients and families, link to services including DRCs

Initially, Reentry1 targeted adult male and female offenders sentenced to the ACJ with minimum sentences of six to eight months. Eligibility criteria narrowed in the first year of program operations to focus on just medium- and high-risk offenders (previously, the program took low-risk offenders as well) with at least five months remaining. The enrollment process also changed with the introduction of random assignment procedures under the National Institute of Justice-sponsored evaluation of FY 2009 SCA sites.

Additionally, there has been significant turnover in case management staff: the Reentry1 Family Support Specialist left in November 2012, and the position was not refilled, leaving the Reentry Specialists to assume some of the responsibilities of that position. In turn, nearly all the Reentry

Specialists changed during the study period, and the Reentry Specialist Manager also resigned. A review of 31 randomly selected case files indicates that Reentry1 clients had multiple Reentry Specialist case managers (two on average) during their tenure in the program: just one-third of these clients had the same Reentry Specialists throughout their program participation; in contrast, nearly 40 percent ($N= 12$) had three or more case managers. Many clients raised the issue of staff turnover and its impact during the study's participant focus groups.

The program also changed curriculum at least once: the *Why Knot* marriage program was replaced with a relationship-focused curriculum in 2012.

Lastly, the Reentry Pod opened in summer 2012.⁸ Offering a structured living environment designed to reinforce the programming principles that inmates participating in reentry services were exposed to, inmates could apply to be transferred to the Pod. Once accepted, inmates attended an orientation that included a review of Pod policy and responses for infractions of Pod policy, as well as the Pod daily schedule. The schedule was organized around Pod responsibilities (chores) and participation in designated programming and services in and off the Pod; evening activities included educational, instructional, and recreation activities. Inmates who complied with Pod policy and service plans could then be transferred to the jail's Alternative House program or to a unit for inmate workers, depending on the inmate's service plan, or they could remain on the Pod until release.

Reentry2

Allegheny County Adult Probation, with the support of the ACJC and its partners, pursued and received Second Chance Act funding in fall 2011 to enhance coordination and service provision for medium- to high-risk offenders returning to the local community after jail, who either could not be served by the Reentry1 program or who did not meet the reentry program's minimum sentence length criteria. Under Reentry2, five designated probation officers supervise returning jail inmates and coordinate their transition services post-release. Participation is mandatory and stipulated in the offender's supervision orders.

The Reentry2 program, in many ways, represented a logical progression of Adult Probation's increasing orientation toward and adoption of both evidence-based practices and "client-centered" supervision strategies. In 2006, for example, Probation began supervising clients by level of risk (to reoffend) as opposed to offense type. In 2011, the department moved toward mobile monitoring, largely doing away with office-based supervision and sending officers out into the field with laptops to

meet with their clients (Allegheny County Adult Probation Department 2012 Annual Report). In 2012, Adult Probation opened the second of its two Day Reporting Centers (DRCs); the first serves county probationers and parolees living in the eastern segment of the county, and the second serves clients living in the southern part of the county. Serving as hubs for services and programming, the DRCs completed the department's vision for more field-based supervision and greater client access to evidence-based programming. At the DRCs, probationers and parolees can access a computer lab to complete job searches and develop resumes, attend cognitive-based therapy and relapse prevention classes, and work on their GEDs; urinalysis testing is also conducted at the DRCs.

PRERELEASE CORE COMPONENTS

Risk/needs assessment, reentry and transition planning, and in-jail programming make up the program's core prerelease components. Needs were assessed in-jail via the Level of Service Inventory-Revised (LSI-R) assessment, administered by the participant's designated Reentry2 PO. An individual Offender Supervision Plan (OSP) was developed based on the results of the LSI-R and the client's input. Referrals to in-jail services and programming were then submitted to the jail's Reentry Center. Reentry2 clients could access any of the jail's reentry services, and were designated for priority placement.

Under the Reentry2 program model, POs would meet regularly with clients to track progress and craft transition plans. Typically, these plans covered housing (where and with whom the offender planned to reside), employment, and any reporting requirements, including the date of the first Adult Probation meeting after release. During the last portion of the client's incarceration, the PO worked to verify the home plan and to arrange for housing if the planned location was deemed unsuitable or the arrangement was undesirable to any party.

POST-RELEASE CORE COMPONENTS

Supervision by the Reentry2 PO and linkage to services through Probation's DRCs comprised the program's core post-release components. As noted above, the DRCs function as one-stop shops for services and programming, although POs may also refer clients to services outside the DRC.

IMPLEMENTATION

Urban-JPC researchers received data on 277 Reentry2 clients: 238 men and 37 women,⁹ of whom nearly two-thirds (58 percent) were African American; the remainder (40 percent) were white. On average, Reentry2 clients were 30 years old. Eight-four percent ($N = 232$) scored as moderate- to high-risk for reoffending on the Proxy risk screener.

By and large, stakeholders reported few if any modifications to the program model. As discussed later in this report (see section 3—Fidelity Assessment Findings and Implications), a review of 45 randomly selected Reentry2 case files indicated strong fidelity to the Reentry2 model: 86 percent of the cases reviewed had a completed LSI-R and OSP, 84 percent indicated prerelease PO-client meetings with three-quarters showing multiple prerelease contacts (ranging from 2 to 14 visits), and widespread use of the DRCs to access and receive programming and services post-release.

Study Objectives

ACJC stakeholders were eager for actionable information on program performance and commissioned the current study for that reason. With this in mind, and given the changes that had already been made or were underway at the time of the evaluation, researchers focused on analyses that could inform program refinements, while also gathering and examining evidence of program effectiveness. Urban-JPC researchers employed an action research approach that guided evaluation activities and featured frequent feedback loops to supply stakeholders with needed information. Several interim briefings¹⁰ were held with ACJC stakeholders to share emerging insights from the evaluation and responses to stakeholder requests for information on best practices, evidence-based practices, and programming. The following sections briefly review the extant reentry research, including the evidence specific to core correctional practices.

Lessons from Extant Reentry Research

While addressing offenders' multiple needs is critical to effective reentry, only limited research exists on the impact of "holistic" reentry programs (i.e., programs offering a coordinated suite of pre- and post-release services designed to meet the offender's array of needs). The National Reentry Resource Center's "What Works in Reentry" Clearinghouse, which profiles only studies meeting specific methodological rigor, currently¹¹ lists nine holistic reentry programs¹² that have been subject to sufficient empirical scrutiny to determine their impact. Several of these programs have been found to reduce recidivism and substance abuse and to support post-release employment. Specifically, six of the nine studies were found to reduce recidivism (three had strong effects; the other three had modest effects), while two studies had no effect and one had harmful effects (Project Greenlight).

The New Jersey Day Reporting Center and Halfway Back Programs, which provide a broad array of reentry services to parolees, were found to reduce the likelihood of rearrest and reconviction by 64 to 73 percent (Ostermann 2009). The Boston Reentry Initiative, which pairs returning inmates with both services and mentors, was found to reduce the risk of rearrest for program clients by about 34 percent (Braga et al. 2009).

In addition to improving post-release outcomes, reentry programs may prove cost-beneficial for the implementing government: California's Preventing Parolee Crime Program, which provided employment assistance, educational support, and substance abuse treatment, was found to produce modest reductions in reincarceration and to return \$1.43 in social benefits for every dollar invested (Zhang et al. 2006a; Zhang et al. 2006b).

However, even well-established reentry programs are not uniformly successful. The CREST therapeutic community program was found to reduce recidivism among men, but early evaluations have not found this effect for women (Farrell 2000; Inciardi et al. 2004; Martin et al. 1999). One holistic program, Project Greenlight, was found to have a harmful effect on its participants; two years after program release, clients were found to: have a higher arrest rate, experience more parole revocations, and be at greater risk for both rearrest and new felonies. Some research attributes this to the lack of a community component, as well as the relative newness of the program (it was evaluated in the first year of implementation), which might account for the program's negative impacts (Ritter 2006; Wilson 2007; Wilson and Davis 2006).

While reentry findings remain mixed, it should be noted that several of the studies documenting programs with positive findings were published six to eight years after program inception; this suggests that evaluation also took place quite some time after program implementation and that program operations were likely solidified and quite stable. (In contrast, and as discussed in later sections of this report, Allegheny County's Reentry1 and Reentry2 programs had been in operation for less than two years when this study began.) Only two of the documented programs with positive findings, the Boston Reentry Initiative and Crest Therapeutic Community Program, used a similar strategy to the Allegheny County reentry programs with pre- and post-release services linked by intensive case management; both measured recidivism in terms of post-release rearrests. Additionally, few of these studies addressed the implementation fidelity or quality of the programs at the time they were evaluated despite consensus that poor fidelity is a key challenge for creating a successful reentry program (Petersilia 2004; Seiter and Kadela 2003; Travis and Visser 2005). But while developing high-performing programs can be challenging, a number of best-practices for successful reentry programming have emerged.¹³

Importance of Core Correctional Practices

The now sizable body of reentry research literature also points to a number of core practices as central to effective reentry. Successful programs start in correctional settings (Gaes et al. 1999) and incorporate collaborative community partnerships to facilitate service delivery (Hammett et al. 2001). Research shows that reentry programs should be built around critical features such as systematic risk assessments and rational eligibility criteria. Moreover, comprehensive case-managed services should be tailored to specific needs, including mental health and substance abuse treatment (Andrews et al. 1990; Aos et al. 2006; Cullen and Gendreau 2000; Gaes et al. 1999; Landenberger and Lipsey 2005; MacKenzie 2006; McGuire 2001; Rossman et al. 1999), vocational training (Aos et al. 2006; Gaes 2008; Wilson et al. 2000), employment readiness and placement (Bernstein and Houston 2000; Rossman and Roman 2003; Rossman et al. 1999; Visher et al. 2003), and housing (Lowenkamp and Latessa 2002; Roman et al. 2009; Roman and Travis 2004). Ensuring fidelity in service delivery is equally important. Systems need to be in place to facilitate routine monitoring of service use to ensure that clients receive at least 200 hours of service delivery, often considered a benchmark for sufficient service dosage (Latessa 2011; Matthews et al. 2001).

Similarly, discharge or transition planning is deemed critical to successful reentry (Altschuler and Armstrong 1994; Petersilia 1999; Solomon et al. 2008; Taxman 1999), particularly for individuals with high levels of need (Clear et al. 1993), as this information can be conveyed to community-based service providers to ensure continuity of care (Gaes et al. 1999; Osher et al. 2002). Proper risk and needs assessments are crucial in this regard (Gendreau et al. 1996). Screening for risk level helps practitioners determine which offenders should be targeted for in-depth assessment and interventions (Transition from Jail to Community Toolkit 2011). Through the efforts of evidence-based initiatives such as the National Institute of Correction's Transition from Prison to Community and Transition from Jail to Community (TJC), many corrections departments and jails have begun using needs assessment tools to establish appropriate eligibility criteria for prerelease treatment programs so that they can tailor the programs to participant needs (Simpson and Knight 2007). Jails are likewise increasingly implementing such procedures to ensure scarce program resources are allocated most efficiently (i.e., targeting the highest risk inmates for intensive programming and services, consistent with the research). Throughout the reentry process clients should be reassessed to measure their progress and the degree to which needs are being addressed (Domurad et al. 2010; Gendreau et al. 2004; Matthews et al. 2001).

Family engagement and support is another critical component of reentry planning that research identifies as predictive of positive reentry outcomes (Dowden and Andrews 2003; La Vigne et al. 2008; Shollenberger 2009). It has been well established that incarceration has negative consequences for

family members of incarcerated persons, including difficulties maintaining financial stability and support for child care previously provided by the incarcerated parent (Geller et al. 2009; Smith et al. 2007). Prior research indicates that the times of initial incarceration and immediately following release are particularly stressful periods for children and families, and that this stress is heightened when parents cycle in and out of jail repeatedly (Davies et al. 2008; Wildeman and Western 2010;). Additional research identifies the specific issues affecting children and their incarcerated parents in Allegheny County. An Urban Institute study found that 17 percent of children in the Allegheny County foster care system had a mother who was booked into jail at least once over a 20-year period (Brazzell 2008), and a survey of Allegheny County jail inmates found that most children were under the care of their incarcerated parent before the parent's incarceration as opposed to under the formal supervision of social services (Walker 2005). Shoring up support both for *and* from family members can yield benefits for those exiting jail and the families to which they return.

While much of the knowledge base regarding prisoner reentry is transferrable to jail reentry, jails and the populations they house have distinct characteristics that require particular attention. Like prisoners, jail inmates have many needs that dramatically exceed the nonincarcerated population, including substance abuse and dependence (Karberg and James 2005), mental illness (James and Glaze 2006), education (Harlow 2003), employment (Geller et al. 2006), and housing needs (Greenberg and Rosenheck 2008). However, the average jail sentence is much shorter than the average prison sentence, which means that jail stays may not afford enough time to provide adequate “dosage” (i.e., amount of treatment) for a given program (Gendreau et al. 1996). There is also higher turnover with the jail population, which can impede efforts to build therapeutic rapport and continuity of care.

On the positive side, jails have at least one distinct advantage over prisons with regard to reentry: their proximity to the local community allows for greater involvement of community-based providers through in-reach activities and within a reentry collaborative partnership—arguably, both facilitate better reentry outcomes at the individual and system levels. Indeed, research documenting the effectiveness of a jail transition program in New York City found that individuals who completed at least 90 days of post-release services were significantly less likely to return to jail and significantly more likely to stay out of jail for longer (White et al. 2008).

In addition to the practices and policies outlined above, the reentry field has also made great strides in identifying the characteristics of effective correctional interventions and programming (Carter and Sankovitz 2014; Gendreau et al. 2004; Latessa 2010; Matthews et al. 2001). Matthews and colleagues (2001, 455–56), summarizing the extant research, lists the following 11 “principles of effective intervention”:

1. Effective interventions are behavioral in nature.
2. Levels of service should be matched to the risk level of the offender.
3. Offenders should be referred to services designed to address their specific, assessed criminogenic needs (e.g., antisocial attitudes, substance abuse, family communication).
4. Treatment approaches are matched to the learning style or personality of the offender.
5. High risk offenders require intensive services, occupying 40–70 percent of the offenders' time for a 3- to 9-month period.
6. Effective interventions are highly structured and contingencies are enforced in a firm, but fair manner.
7. Staff relate to offenders in interpersonally sensitive and constructive ways, and are trained and supervised appropriately.
8. Staff members monitor offender change on intermediate targets of treatment.
9. Relapse prevention and aftercare services are employed in the community to monitor and anticipate problem situations and to train offenders to rehearse alternative behaviors.
10. Family members or significant others are trained how to assist clients during problem situations.
11. High levels of advocacy and brokerage occur if community services are appropriate.

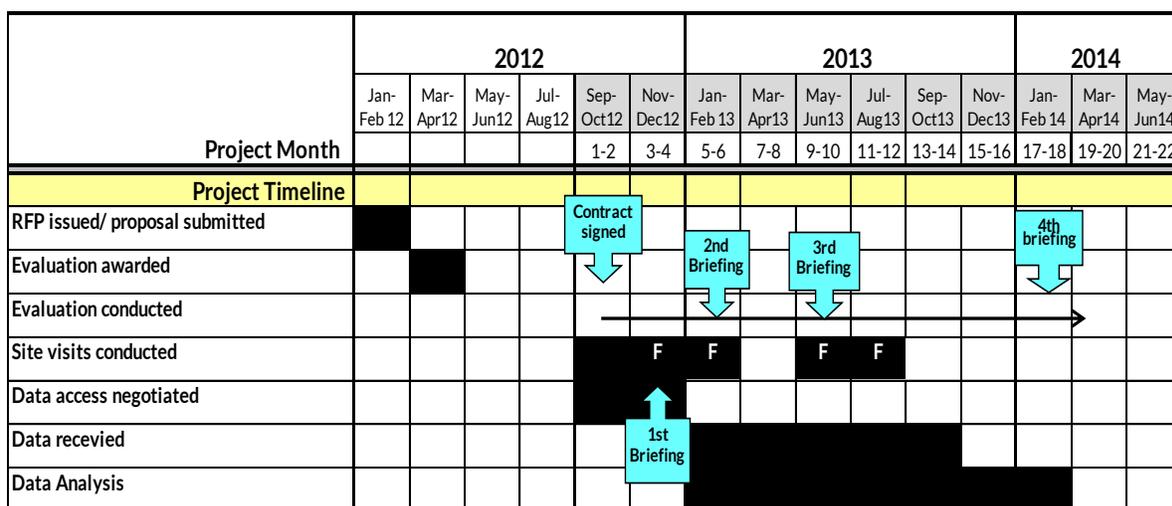
These eleven criteria have since been subsumed under the Risk-Need-Responsivity (RNR) principle, which states that who is targeted for intervention matters (the risk principle), using interventions that target dynamic criminogenic needs matters (the needs principle), and how system actors engage with offenders to facilitate change matters (the responsivity principle) (Carter and Sankovitz 2014: 6–8). Ongoing research suggests that this set of core correctional practices and principles, when implemented in concert and with fidelity as part of a holistic reentry strategy, reduces recidivism (Latessa 2010). Tools such as the Correctional Program Assessment Inventory have been developed to assess how well a program meets these criteria. As such, these criteria figured prominently in the study's assessment of the ACJC reentry programs' alignment with core correctional practices and principles.

Section 2. Study Design, Methods, and Data Sources

The purpose of the ACJC reentry evaluation was to answer critical questions about program performance, including the extent to which the program functions as intended, whether services are delivered as designed, and for whom (which participants) the program is most effective. An action research framework guided the evaluation’s activities and ensured stakeholders received frequent feedback and actionable information applicable to real time program operations. Figure 2 portrays the project’s actual timeline including briefings and deliverables.

The evaluation approach featured two key components: a fidelity assessment and impact analysis. The evaluation drew on multiple data sources and employed a mixed-methods approach, as discussed in detail below.

FIGURE 2
ACJC Evaluation Timeline: 2012 to 2014



F = focus group

Fidelity Assessment

The fidelity assessment examined the extent to which the ACJC’s reentry programs were implemented and operating as intended; identified factors associated with successful program implementation, potential barriers that inhibit program performance, and lessons learned; and assessed the programs’ alignment with core correctional practices. The assessment’s ultimate aim was to inform ACJC decisions about potential program modifications and additional program planning. Data sources included semi-structured interviews with ACJC stakeholders, including program staff and partners, client and family member focus groups, and analysis of individual-level program and administrative records.

Stakeholder Interviews

Urban-JPC researchers conducted five site visits and approximately 40 semi-structured interviews with nearly 60 core stakeholders (ACJC members, reentry program staff, probation staff, family support staff, service providers, and others) to document the progress of reentry program operations, including milestones and other critical events, pressing policy or procedural issues that could affect program operations, collaboration, information exchange, and data. These interviews also solicited stakeholder recommendations for program improvements. The research team observed program activities (structured classes, the ACJ reentry pod) and collected materials that documented plans, policies, practices, difficulties encountered, and accomplishments.

Client and Family Member Focus Groups

Between November 2012 and August 2013, Urban-JPC researchers conducted seven 90-minute focus groups—five groups with reentry program participants, including one in the Allegheny County Jail to capture prerelease program experiences, and two with family members. Participants received nominal compensation to thank them for their participation; light refreshments were also served.

CLIENT FOCUS GROUPS

The first set of client focus groups targeted both Reentry1 (specifically, 10 Phase 1 participants in the Allegheny County Jail receiving prerelease services) and Reentry2 program participants. Focus groups with Reentry2 participants took place in the community at Probation’s two DRCs.¹⁴ Participants in

these initial three focus groups were entirely male. Discussion topics differed according to program type (i.e., Reentry1 or Reentry2) but generally explored participant impressions of the program, services received, and recommendations for program improvement. As would be expected, the Reentry1 focus group discussion explored topics specific to prerelease programming experiences such as

1. exposure to and impressions of in-jail programming;
2. risk/needs assessment process and development of individualized service plans and, as applicable, development of transition plans;
3. life on the reentry pod;
4. interactions with and impressions of the family support component, Reentry Specialists, and Probation liaisons, including frequency and nature of contacts;
5. motivation for program participation;
6. overall impressions of the program; and
7. expectations about the transition process and life in the community.

Discussions with Reentry2 clients focused on

1. program experiences, including the range of services accessed in the jail and in the community, and the adequacy of those services in relation to perceived needs;
2. interactions and relationship with their designated Reentry2 probation officers;
3. challenges encountered during their transition to the community, and the extent to which the benefits of program participation addressed those challenges; and
4. receipt of sanctions or rewards.

In February 2013, Urban-JPC researchers conducted two community-based focus groups with 19 Reentry1 participants active in Phase 2 of the program. Focus group participants were predominantly male ($N= 16$). Length of time in the program (and community) post-release varied greatly among participants: some had been released just weeks before the focus group, while others had been in the community almost one year. Similar to earlier focus groups, Urban-JPC researchers used a structured protocol to cover a core set of topics ranging from participant impressions of the program to services received, contact with their respective Reentry Specialists, post-release reentry experiences and challenges, and recommendations for program improvement.

Consistent with the evaluation's action research approach, Urban-JPC researchers compiled and provided ACJC stakeholders with memoranda after each focus group that aggregated and summarized participant feedback around critical themes and common program dimensions such as (1) access to

programming pre- and post-release; (2) engagement in and impressions of service and reentry planning processes; (3) impressions of and experiences with program supports, namely interactions with the programs' respective core staff; (4) reentry experiences; and (5) overall program impressions including strengths, gaps, and recommendations for improvement. The evaluation team also prepared a summary report comparing and contrasting Reentry1 and Reentry2 participant experiences and feedback.

FAMILY MEMBER FOCUS GROUPS

Family member focus groups explored: the degree to which Allegheny County's reentry programs engaged family members in the reentry process and fostered inmate-family contact during periods of incarceration, as well as exposure to program services and supports relative to expressed needs. Impressions of preparedness (for the incarcerated individual's return) and satisfaction with the program were also topics of discussion. Family member perspectives helped identify areas for potential program improvement.

Both focus groups targeted family members who had participated in some aspect of the family support services offered by Allegheny County's reentry programs. Approximately 12 individuals participated across the two groups.¹⁵ All participants were female and included mothers, partners, sisters, and the adult children of the incarcerated individual; the incarcerated individuals (to whom the family members were attached) included both men and women. Focus group participants also varied significantly with respect to the length of time they had been engaged with the program: some were only connected recently to the program, while others had been involved with the program for approximately two years. Several, but not all, were the caregivers of the incarcerated family member's children.

Case File Review

Urban-JPC researchers reviewed 76 program participant files (31 Reentry1 cases and 45 Reentry2 cases) representing a mix of active and closed cases, including program successes and failures, to systemically assess the use of evidence-based practices including (1) routine risk/needs assessment and reassessment consistent with core correctional practice; (2) case planning and needs-matching, specifically the extent to which individual service plans addressed assessed needs; (3) case management and supervision strategies consistent with stated program objectives, including frequency and nature of contacts pre- and post-release; (4) service use and dosage; and (5) use of sanctions and rewards. Lastly, researchers also documented the contents and completeness of case files to inform the study's quality

assurance (QA) recommendations (i.e., did files typically include the same elements, were information releases, assessment results, and supervision orders routinely included, etc.).

Analysis of Reentry1 Program Data

The evaluation team spent significant time mining the Reentry1 program database, which documents Reentry1 program activities and actions including program discharge and client recidivism. Analysis focused on 316 Reentry1 program participants¹⁶ who entered the program between June 2010 and February 15, 2013¹⁷—the date these data were extracted and provided to the Urban Institute for analysis. Using the Reentry1 database, Urban-JPC researchers assembled profiles of successful and unsuccessful program participants, examined the scope and breadth of client program experiences relative to assessed risks and needs and service delivery including intensive reentry case management, and sought to quantify family support utilization for the family support sub-analyses. Urban-JPC researchers also used the Reentry1 database to develop a set of performance indicators (process and outcome) to evaluate adherence to program guidelines. These indicators served to ground actual practice, while offering a structure for on-going monitoring, management, and improvement.

Of the 316 Reentry1 cases available for analysis as of February 15, 2013, 91 percent ($N= 287$) were male. Approximately 60 percent ($N= 182$) of Reentry1 participants were African American and nearly 40 percent ($N= 129$) were white; a nominal number were Latino or Native American. While most clients were in their early thirties (average age was 33), ages ranged from 19 to 72.

Lastly, program intake varied considerably by year: in 2010, 113 clients entered the program, then enrollment dipped to just 84 clients in 2011. In 2012, enrollment topped 106 cases. Thirteen clients had been enrolled as of mid-February 2013.

Impact Analysis

The impact analysis focused exclusively on assessing the effect of the two reentry programs on participant criminal justice outcomes, specifically rearrests, time to rearrest, and probation violations. The study had intended to also examine re-convictions and returns to the Allegheny County Jail, but structural issues with these data files precluded analyses within the remaining project resources and timeline. Key research questions guiding the impact analysis included:

1. Does reentry program participation reduce recidivism, specifically post-release rearrests?
2. Does reentry program participation increase supervision compliance as evidenced by decreased probation supervision violations?
3. For whom is the reentry program most effective (Reentry1 analysis only¹⁸)?

Three data sources supported this analysis: the Adult Probation Case Management System (APCMS), the Common Pleas Case Management System (CPCMS), and the Reentry1 database. The APCMS is maintained by Adult Probation. The system provides information on probation violations. CPCMS is maintained by the Allegheny Court of Common Pleas and provides demographic, criminal history, and charging information on offenders. As noted earlier, the Reentry1 program database was developed specifically to record information about Reentry1 clients and offers extensive information about the services these clients received, their entry and exit dates from the program, and their entry and exit dates from the Allegheny County jail.

A quasi-experimental design was employed to evaluate the impact of the Reentry1 and Reentry2 programs on recidivism. The study identified groups of clients who participated in either the Reentry1 or Reentry2 program and used propensity score analyses to identify comparison groups that did not receive the treatment, but were otherwise comparable to the Reentry program client groups in terms of key demographic indicators and criminal histories.

Defining the Treatment and Comparison Groups

Reentry1 and Reentry2 had significant structural and philosophical differences in their program logic and operation. Reentry1 is voluntary, while participation in Reentry2 is a mandatory condition of post-release supervision; case management services also differed between the programs. As such, the study chose to *analyze the impact of each program independently* rather than pool the data. A treatment group for each reentry program and a matched weighted comparison sample were drawn from the administrative records listed in the prior section using propensity score matching (PSM) techniques.

A comparison between these groups and the Reentry1 and Reentry2 program groups was used to determine the Reentry programs' effects on rearrest and probation compliance.

Constructing the Comparison Groups

Initially, matched comparison groups for Reentry1 and Reentry2 participants were constructed using PSM techniques. The PSM drew from multiple data sources (APCMS and CPCMS files) and began with a sample of more than 10,000 offenders who had been sentenced to the Allegheny County jail between 2008 and 2012 for a period of six months or longer, without holds, and for whom a Proxy risk score had been generated (see the Impact Analysis section and Appendix A for more detail on the construction of the comparison groups). Of these individuals, 305 were identified as Reentry1 program participants and 250 as Reentry2 program participants. Based on the attributes of these clients, a comparison group with similar attributes was assembled from other inmates involved in the Allegheny County justice system. While groups were initially created on a one-to-one basis (i.e., for each Reentry1 client in the analysis sample, there would be a similar nonprogram participant in the comparison sample), challenges linking matching clients with their administrative records data subsequently made the matched case-control design out of balance. Therefore, statistical weights based on another set of propensity scores were developed and applied to the data to make Reentry1 and Reentry2 participants look more like their comparison counterparts. While this approach restored balance to the groups, the one-to-one match could not be retained.

Analysis Method

Logistic regression and Kaplan-Meier curves were applied to the assembled treatment and comparison groups to determine the effect of Reentry1 and Reentry2 programs on the probability of rearrest. Logistic regression estimated the probability of rearrest for both treatment and comparison groups; the difference between rearrest estimates for these two groups can be attributed to the impact of the Reentry1 or Reentry2 program.¹⁹

Section 3. Fidelity Assessment Findings and Implications

The fidelity assessment was designed to answer three key questions:

1. Do the Reentry1 and Reentry2 programs function as intended?
2. Do the programs align with core correctional practices found to reduce recidivism?
3. Are there specific areas for program improvement?

Tracking the programs' evolution, including changes to key program components and the rationale for those changes, was a related task.

Does Reentry1 Function as Intended?

Analysis of the Reentry1 program database coupled with Urban-JPC researchers' case file review indicates that the Reentry1 program largely operated as intended, and operations largely aligned with core correctional practices:

- **Reentry1 targets the highest risk inmates for intensive intervention.** Ninety-two percent of the Reentry1 case files reviewed by Urban-JPC researchers scored as medium-to high-risk on the Proxy. This finding is consistent with analysis of the Reentry1 database. Although Proxy scores were not consistently documented in the Reentry1 database until 2011 and thus, Proxy data existed for only 178 of the 316 cases available for analysis, 93 percent ($N= 164$) scored as medium- or high-risk for reoffending. The 14 cases screened as low risk all occurred in 2011. The absence of low-risk cases in subsequent years indicates strong adherence to the program model's target population criteria. Likewise, screening for risk of reoffending using the Proxy become more routine over the course of the program: 100 percent of enrolled clients had a Proxy score in 2012, up from 80 percent of enrollees in 2011. However, just 38 percent of clients enrolled in 2013 had a recorded Proxy score.
- **Assessment of criminogenic risk/needs routinely performed and service plans developed.** Ninety-seven percent of the Reentry1 case files ($N= 30$) reviewed had recorded risk/needs assessments and 100 percent of those cases with recorded MoCo assessments also had required Phase 1 reentry plans; 63 percent of those cases eligible to have both Phase 1 and 2

case plans did.²⁰ Again, review of the Reentry1 database supports this finding: approximately 89 percent of Reentry1 clients had required service plans. Sixty-three percent (of those eligible) had both Phase 1 and Phase 2 case plans.

- **Average duration mirrors program model.** As discussed earlier in this report, Reentry1 program participants logged an average of 458 days or roughly 15 months in the program. Those clients who successfully completed the program spent an average of 590 days or 19 months in the program. In either case, the average duration of Phase 1 was a little over six months (with a range covering 3 to 743 days); clients spent about 12 months (359 days; range: 72 to 630 days) in Phase 2. Both are consistent with the specified program model.
- **Evidence of intensive service coordination/case management consistent with the program model.** Case file review suggests Reentry Specialists maintained regular contact with clients both pre- and post-release and at levels specified by the program model. This observation mirrors independent client accounts obtained through various focus groups with Reentry1 clients both in the jail and in the community. Additionally, clients reported frequent and constructive interactions with their Reentry Specialists, except during periods of staff turnover when staff changes were not always communicated to clients, creating confusion and some reported lapse in services. Focus group clients consistently reported prerelease contact with the program's Reentry PO liaison; however, these contacts were not recorded in the Reentry1 database or case files; therefore, a measure of contact could not be computed or verified. Urban-JPC researchers, therefore, recommend recording client contacts with both PO and Reentry Specialists in order provide an accurate picture of support pre- and post-release.
- **Solid rate of program enrollment to referral.** In addition to accessing a wide range of programs and services, the program also demonstrated a solid rate of enrollment to referral: 55 to 95 percent of referrals led to enrollment across five core programs examined, indicating that clients were actively engaged in recommended services—a challenging connection for many other programs.
- **Clients accessed a wide range of pre- and post-release services.** Analysis of the Reentry1 database indicates that at least 11 programs and services²¹ were accessed by upwards of 50 clients. The most prevalent programs accessed *before* release included *Thinking for a Change* ($N= 211$), job readiness ($N= 186$), life skills ($N= 153$), family support ($N= 128$), and parenting classes ($N= 115$). These services and two others—drug and alcohol classes ($N= 110$) and ACHS mental health services ($N= 104$)— were accessed by at least one-third of all Reentry1 clients in

Phase 1. In turn, *Thinking for a Change*, family support, job readiness, and alcohol and drug services comprised the most prevalent services delivered in Phase 2. In general, a relatively small share of Reentry1 participants accessed formal services and programs post-release. This makes sense given that service delivery was largely frontloaded (i.e., designed to occur before release when inmates are perhaps most accessible and amenable to programming) and that the nature of post-release service provision, by client and staff accounts, tended to shift toward logistical (e.g., transportation, obtaining identification, meeting basic needs) and emotional (negotiating relationships, reporting requirements) assistance and supports.

- **Evidence of assessment driving service plans.** While challenging to gauge (i.e., MoCo assessment results are not automated), the research team’s review of Reentry1 case files found evidence that assessment results informed both Phase 1 and Phase 2 plans. There were, however, some glaring exceptions (one assessment noted a client’s recent preincarceration opiate use, yet the case file did not record a recommendation for substance abuse treatment) and seemingly inappropriate referrals (a client with adult offspring was referred to parenting classes). Both examples suggest a need for a quality assurance process that includes regular review of assessment findings and recommendations to ensure clients are linked to the most appropriate services given their assessed needs.

What Did Successful Reentry1 Participants Look Like?

Participants who were marked as successful Reentry1 program were more likely to have (1) a Proxy score on file and to be medium to high-risk for reoffending; (2) service plans for both Phase 1 and 2 on file; and (3) received core services, specifically T4C, family support, job readiness and mental health services.

It is important to note, however, that the program continued to work with individuals who were rearrested and/or returned to jail and that these individuals could be counted as successful completers if they ultimately satisfied their reentry goals. For research purposes, such individuals were counted as failures in the Impact Analysis.

Recognizing that the path to a crime-free life is not often linear, the program's decision to continue work with such individuals makes sense. For future evaluative efforts, however, Urban-JPC researchers encourage the program to count these individuals as "Complete-program compliant" rather than "successful" s they are qualitatively different from those who are arrest-free when they complete the program.

Does Reentry1 Align with Core Correctional Practices?

The data in the preceding section indicate an alignment with core correctional practices. Reentry1 clearly targeted offenders at medium- to high-risk for reoffending for intensive prerelease intervention, used assessment results to inform service and transition planning, and provided continued and strategic support through intensive case management post-release. Additionally, review of service referrals and receipt indicates that cognitive behavioral interventions were emphasized pre-and post-release and often employed the same programming approaches (*Thinking for a Change*, for example) to ensure continuity. Because actual service utilization and dosage could not easily be measured, we strongly recommend that Allegheny County establish mechanisms to monitor whether programming and service dosage approach or meet the recommended thresholds necessary for recidivism reduction as outlined in the literature: 300 hours for high-risk individuals; 200 hours for moderate- to high-risk individuals, and 100 hours for moderate risk individuals (Carter and Sankovitz 2014) over a three to nine month period (Matthews et al. 2001).

Are There Specific Areas for Reentry1 Program Improvement?

The Reentry1 program in operation before and during this study has many strengths including sound program logic. Nonetheless, the fidelity assessment identified two key areas where the program could be further refined and strengthened, specifically:

- **Assessment and transition planning.** Assessment could be improved by implementing an automated, validated instrument that generates an overall score and individual criminogenic need domain scores. As discussed earlier in this report, Phase 1 service planning relies on the MoCo assessment, which is neither automated nor scored. Both factors hamper review, and potentially hamper use across stakeholder groups. Additionally, key partners use different assessment instruments: ACJ uses the MoCo for Phase 1 planning while Probation uses the LSI-R, which is both automated and scored, to inform Phase 2 transition planning. The extent to which these two assessments are aligned is unclear. Implementing a single, universal validated and automated risk/needs assessment that generates both an overall risk/need score and scores by need domain would not only enhance needs-matching but would also “standardize” partners’ understanding of and familiarity with criminogenic risks and needs while offering a common foundation to build dynamic transition/reentry case plans.
- **Quality assurance.** Because actual service utilization and dosage could not easily be measured, we strongly recommend that Allegheny County establish mechanisms to monitor whether programming and service dosage approach or meet the recommended thresholds necessary for recidivism reduction, as outlined in the literature: 300 hours for high-risk individuals; 200 hours for medium- to high-risk individuals, and 100 hours for medium-risk individuals (Carter and Sankovitz 2014) over a three- to nine-month period (Matthews et al. 2001).

Does Reentry2 Function as Intended?

Urban-JPC researchers’ case file review ($N = 45$) indicates that the Reentry2 program largely operates as intended, and that operations largely align with core correctional practices:

- **Reentry2 targets and assesses the highest risk inmates for intensive intervention.** Ninety-five percent of the Reentry2 case files reviewed by Urban-JPC researchers scored as medium-to high-risk on the Proxy. This indicates the Reentry2 program is successfully reaching its target population.

- **Assessment of criminogenic risk/needs routinely performed and service plans developed.** Eighty-six percent of cases reviewed had a recorded initial LSI-R assessment²² and the majority had OSPs. It is important to note, however, that while 95 percent of Reentry2 cases reviewed scored as medium- to high-risk on the Proxy, approximately 22 percent scored as low risk (overall score of 19 or lower) on the LSI-R. This divergence suggests issues exist with respect to either assessment procedures or scoring as the two tools generally align. Regular review of Proxy and LSI-R results would allow early detection of any issues with either scoring or administration. In turn, periodic staff training on the LSI-R and its administration would enhance fidelity.
- **Evidence of prerelease contacts and service coordination consistent with the Reentry2 program model.** Case file review suggests Reentry2 POs typically initiated and maintained contact with clients pre- and post-release as specified by the program model.²³ Specifically, 84 percent of case file recorded prerelease contacts between the inmates and their POs; the number of prerelease contacts ranged from one to eight and varied by PO (i.e., some POs registered more client contacts than others). This is consistent with focus group feedback obtained from Reentry2 clients: while many reported prerelease contact with their PO, several did not report any contact. Those Reentry2 focus group participants who reported prerelease contact with the PO appreciated the opportunity to get to know their POs early on and many reported a strong rapport with their POs. These individuals also stated that their POs had explained service options to them, specifically employment and housing programs and provided a reentry plan (i.e., their OSP), as well as information about when their first post-release contact would occur. Among those who had been on supervision previously, many expressed having a better sense of their PO's expectations under this current arrangement and feeling better equipped to meet them. Again, there was variation in client experiences regarding PO contact and rapport; this variation seemingly underscores the need to routinize contacts as well as the tangible benefit of doing so (i.e., healthier rapport, better client preparedness).
- **Consistent post-release contact.** Three-quarters of Reentry2 cases had multiple post-release contacts (ranging from 2 to 14) with their respective POs, as would be expected, across different settings including the client's home and Adult Probation DRCs. Unfortunately, Urban-JPC researchers could not routinely identify jail release dates in the Reentry2 files to determine what portion of cases satisfied the Adult Probation's benchmark that Reentry2 POs meet with clients within 24 to 48 hours of release from jail.

- **Solid service utilization pre- and post-release.** Although Reentry2 focus group participants recounted receipt of a variety of jail-based reentry services prerelease, they were more likely (than their Reentry1 counterparts) to report difficulties in accessing those services. Because Probation case files only recorded post-release services, Urban-JPC researchers could not confirm the range of prerelease services accessed by Reentry2 clients. In contrast, case file review did indicate that Reentry2 clients widely used the DRCs to access services in the community. The vagaries of the Reentry2 case files, however, made it difficult to gauge the scope and quality of needs-matching (i.e., the extent to which LSI-R results drove service referrals and receipt).

Does Reentry2 Align with Core Correctional Practices?

The data in the preceding section indicate an alignment with core correctional practices. Reentry2 clearly targeted medium-and high-risk offenders and risk/needs assessments were regularly conducted using an actuarial tool. As with Reentry1, actual service use and dosage could not easily be measured. Accordingly, Allegheny County should establish mechanisms to monitor whether programming and service dosage approach or meet the recommended thresholds necessary for recidivism reduction as outlined in the literature: 300 hours for high-risk individuals; 200 hours for moderate-to-high risk individuals, and 100 hours for moderate risk individuals (Carter and Sankovitz 2014) over a three to nine month period (Matthews et al. 2001). Likewise, stakeholders should maintain close oversight of service delivery to reentry offenders to monitor the quality of services and fidelity of service delivery to the stated program models (i.e., *Thinking for a Change* and other curricula).

Are There Specific Areas for Reentry2 Program Improvement?

As highlighted throughout the prior section, the fidelity assessment identified areas where the Reentry2 program could be further refined and strengthened, specifically:

- **Assessment.** As discussed, screening and assessment determinations about clients' level of risk to reoffend differed in about 22 percent of the cases reviewed. In these instances, the Proxy risk screener was more likely to score an offender as medium- to high-risk than the LSI-R. This suggests an issue either with scoring or administration of these instruments. Proxy and LSI-R

results should be reviewed regularly to detect and investigate potential issues. Steps should be taken to resolve issues through additional training.

- **Reassessment.** Urban-JPC researchers found no evidence that clients are regularly reassessed, consistent with the principles of effective intervention, to measure progress and adjust services and treatment as needed (Domurad et al. 2010; Gendreau et al. 2004; Matthews et al. 2001). Stakeholders should implement reassessment at three to six month intervals (Genreau et al. 2004:7) and review results to detect changes in dynamic factors and compare those changes to the offender’s level of compliance to inform both service planning and supervision responses (Casey et al. 2011). To ensure POs are properly positioned to reinforce positive behavior change and response to noncompliance, Adult Probation should design and implement a system of incentives and sanctions (Fabelo et al. 2011).
- **Dosage.** Actual service utilization and dosage could not easily be measured in our review. As noted earlier, extant research identifies dosage thresholds necessary for recidivism reduction: 300 hours for high-risk individuals; 200 hours for medium-to-high risk individuals, and 100 hours for medium-risk individuals (Carter and Sankovitz 2014) over a three- to nine-month period (Matthews et al. 2001). Reentry stakeholders should monitor service use to determine if offenders are regularly receiving the recommended dosage of services relative to their assessed risk level and modify service provision accordingly.

Family Support Sub-Analysis

The objective of the family support sub-analysis was threefold:

1. To explore the extent to which the family support component functioned as intended, including what services were routinely delivered and to whom;
2. To assess how participation in the family support component affected participant reentry outcomes; and
3. To ascertain the strengths and weaknesses of the family support component.

Upon a review of available data, it became clear to Urban-JPC researchers that it would not be possible to evaluate the impact of family support services on reentry outcomes. However, the Reentry1 database did indicate the range and prevalence of family support services accessed by Reentry1 participants, as did case file review. Reentry1 client and family member focus groups offered additional

information by which to gauge exposure to relevant services, frequency of contact with family support staff, and the component's perceived strengths and weaknesses, and to obtain recommendations for potential improvement. As discussed below, perceptions of family support services were generally positive, though both clients and family members identified opportunities to improve service delivery.

At the program's inception, family support services had relatively flexible entry criteria, but high demand for the program resulted in restricting service to inmates who are care-givers for children 18 or younger. Family support services are designed to stabilize the family situation of incarcerated clients and to facilitate contact between Reentry1 inmates and their children. To support this objective, Family Support Specialists delivered services to clients in a clear progression, beginning with parenting classes. Viewed as foundational to the program's tiered family support approach, parenting classes used cognitive behavioral therapy to teach clients how to constructively interact with family members including the inmate's children and the other parent or caregiver. A relationship focused curricula (*Why Know?*) was also offered early in the program.

Parenting classes served as the primary mechanism for connecting clients to a broader array of family supports, including coached calls with family members and structured contact visits with their children. The latter served as an incentive for completing the parenting classes (i.e., Reentry1 participants had to complete the parenting classes to participate in structured contacts).

Coached, structured contacts (supervised by the program's Family Support Specialists-FSS) consisted of free phone calls between program participants and their family members and Saturday visitations with their children. The former focused on helping inmates communicate constructively with family members, typically a significant other or the parent of their child. Calls were supervised by the FSS, and clients and their FSS debriefed afterward to address any issues that emerged during the call and to identify how the client could improve his or her communication skills. In addition to facilitating more productive communication with family members, these calls were a prerequisite for structured contact visits between clients and their children. Contact visits consist of supervised visits between inmates and their children in a playroom provided by the jail. Throughout this process, the FSS guides clients in processing lessons from the parenting classes and coaches calls and contact visits.

Family Support Specialists also work with Reentry1 participants' families in the community to prepare the family for the inmate's release.²⁴ In the community, Family Support Specialists taught classes, conducted home visits to support clients' families, and helped returning program participants process their families' expectations (regarding the offender's return to the community). Together, these activities were designed to facilitate a smooth transition and strength the family. Family support

activities were also supplemented by the community group Amachi, which held monthly support groups for clients' family members and facilitated prosocial family events like trips to local museums and sporting events.

Family Support Utilization

Limitations in service access and tracking data restricted analysis of family support service utilization to the 316 Reentry1 program participants in the Reentry1 database. Analysis indicates that at least one-third of Reentry1 clients accessed family support services including parenting classes. Approximately 40 percent of Reentry1 clients ($N= 126$) were recommended for family support services and 44 percent of Reentry1 clients ($N= 140$) were recommended for parenting classes. This suggests that a sizeable minority of Reentry1 clients were deemed to be suitable candidates for family support services. This supports the notion that family support services were being delivered as the program model intended.

While data limitations prevent an evaluation of needs-matching based on these recommendations, it is clear that a significant number of Reentry1 clients received some form of family support in the jail or in the community, though participation in parenting classes in the community post-release declined sharply. In the jail, 41 percent of reentry clients ($N= 128$) received family support services and 36 percent of clients ($N= 115$) received parenting classes. In the community, 37 percent of clients participated in family support services but only four clients participated in parenting classes. Together, these results suggest that a significant number of Reentry1 clients were able to access and receive reentry services, particularly prerelease.

Family members had less consistent service access although the scope of services were similar (i.e., parenting support, support groups, job training, and contact visits), but they did not have a common service profile. Some family members reported significant engagement with both the FSS and support services like job training, while others had very little contact with an FSS. Many of the family members who participated in study focus groups reported first learning about the Family Support component from Amachi during Saturday contact visits.

Perception of Services

Family members of clients in the reentry program were uniformly positive in their assessment of the value of family support services, regardless of the specific services they had received. They suggested

that support services were a good way to “bridge the gap” for incarcerated clients who had become disconnected from their families. Some family members also reported that the services provided and the Reentry Specialists made them feel as though they had a voice in the reentry planning process and improved their perception of their incarcerated family members’ chances for a successful reentry. Family members who had prior experiences dealing with the justice system because of a loved one’s prior incarceration credited the reentry program’s family support services component with providing significantly more positive interactions with the justice system and a better understanding of the process. Family feedback mirrored Reentry1 client feedback: clients had a positive impression of family support services; they valued the enhanced ability to maintain a connection to their families and appreciated the extra supports provided to their family members in the community.

The new format of contact visits was also consistently highlighted by family members as an important improvement: they identified the contact visits as being valuable both for maintaining incarcerated clients’ connections to their children and for promoting responsibility among incarcerated clients by giving them a strong incentive to focus on reentry goals. Several family members noted that they were only willing to bring children to meet with incarcerated family members because of the new format (child-friendly context that encouraged structured play) for contact visits.

Program Recommendations

The key recommendation from clients’ family members was to make information about services more readily available. Family members differed significantly in their knowledge of and connection to available services; Urban-JPC researchers witnessed other family member focus group participants explaining the program and range of available services to other participants and noted the variation in experiences and knowledge. In addition to improved service connection, family members believed that additional mental health, job access, and transportation services would be valuable. In particular, they suggested that access to mental health services was important for enabling participants to effectively use the other services available. Additionally, family members felt that greater access to peer support opportunities like those offered by Amachi could be valuable. Lastly, reentry clients also reported that the timing of the contact visits made it difficult for some families to participate and suggested increasing the number of Saturday contact sessions as well as expanding the schedule to include Sunday contact visits.

Section 4. Impact Evaluation Analyses and Findings

The research team conducted separate evaluations of Reentry1 and Reentry2, assessing each program's impacts on recidivism outcomes as measured by rearrest, time to rearrest, and probation supervision violations. Weighted comparison groups were constructed using administrative data.

Initially, the research team planned to investigate four measures of recidivism: rearrest, probation supervision violations, reconviction, and reincarceration. Rearrest, reconvictions, and reincarceration data were drawn from the CPCMS database; probation information came from the APCMS database. Once data were drawn, it became clear that sufficient issues existed in the data to make linking reconviction and reincarceration events to comparison and program participants infeasible and the scope of the study was redrawn to focus on rearrest and probation compliance for Reentry2.

Analysis Method

As the Reentry1 and Reentry2 programs were applied to a significant number of clients in the ACJ, and both programs started before the analysis, a prospective, experimental design was not possible. For this reason the team determined that a quasi-experimental retrospective design drawing on administrative data collected by Allegheny County would provide the best estimate of the programs' impact. The traditional challenge of using administrative data is that differences in outcomes between the treatment and comparison groups assembled from such data to test the impact of an intervention may be due not to the treatment applied (in this case, Reentry1 and Reentry2), but to underlying differences in the comparison groups constructed from the administrative data.

Propensity score matching (PSM) offers a way to address the observed differences between treatment and comparison groups, and to discern whether any differences in outcomes are the result of an applied treatment intervention (Dehejia and Wahba 1998; Rosenbaum and Rubin 1983, 1984). The PSM approach takes all available background information on a large pool of individuals, including program participants, and creates a single summary metric called propensity scores. This measure indicates how likely one is to participate in either the Reentry1 or Reentry2 program. Based on these scores, program participants are matched to similar nonparticipants, ensuring that both groups are comparable in their distribution of propensity scores. In this way, the PSM approach can reveal what

the recidivism rates of program participants could have been if they had not received the program and gives an indication of how effective the program was at reducing recidivism.

Assembling Comparison and Treatment Samples

Analysis samples were constructed using demographic data, criminal offending risk scores, and criminal history data pulled from the jail database, APCMS and CPCMS. Propensity score matching began with a sample of more than 10,000 offenders who had been admitted to jail between 2008 and 2012. Of these offenders, 305 were identified as Reentry1 program participants, and 250 as Reentry2 program participants. Individual-level attributes in this dataset included race, gender, citizenship status (CITIZEN), marital status (SINGLE), the origin of driver's license (ORIGIN), age, the number of prior arrests (PRIOR), and a proxy score (PROXY). Propensity score analyses focused on these available variables. The final selection model, estimating the chance of receiving treatment, was developed using logistic regression. A total of 79 covariates were used to explain the probability of receiving treatment (i.e., being in the Reentry1 or Reentry2 programs). Among the covariates are individual and case characteristics, and numerous interaction terms of those factors (e.g., white x age, male x number of prior arrests, marital status x proxy score).

The selection model was relatively effective at differentiating treated individuals from untreated individuals. The area under the receiver operating characteristic curve (AUC), an indicator of how well a model predicts an outcome of interest (i.e., entrance into Reentry1 or Reentry2), was 0.70 for Reentry1 and 0.73 for Reentry2. This implies that there is a 70 percent likelihood that a randomly selected Reentry1 offender will be scored higher on the propensity score than a randomly selected non-Reentry1 offender. The AUC of 0.70 is usually considered "acceptable" and the AUC of 0.80 is considered "excellent" so this model provided a suitable tool for identifying offenders for the comparison group (Hosmer and Lemeshow 2000).

Based on the estimated propensity scores, the team matched each Reentry1 and Reentry2 program participant individually to his or her corresponding comparison offender who did not receive treatment. It should be noted that if any of the covariates included in the selection model were missing, the propensity score could not be calculated. Individuals with a missing propensity score were excluded from analyses, and this accounts for the majority of missing data. In addition, if a program participant's propensity score was too high or too low to be matched to a nonparticipant, matching could not be performed and the corresponding program participant was removed from data analysis. This is the generally approved practice in propensity score matching as it improves the internal validity of research

evidence by generating more alike treatment and comparison groups. Table 1 below shows the number of Reentry1 and Reentry2 program participants before and after propensity score matching.

TABLE 1

Number of Program Participants and Matched Comparison Individuals

	Before PSM		After PSM	
	Reentry1	Reentry2	Reentry1	Reentry2
Treatment	305	250	281	220
Comparison			281	220

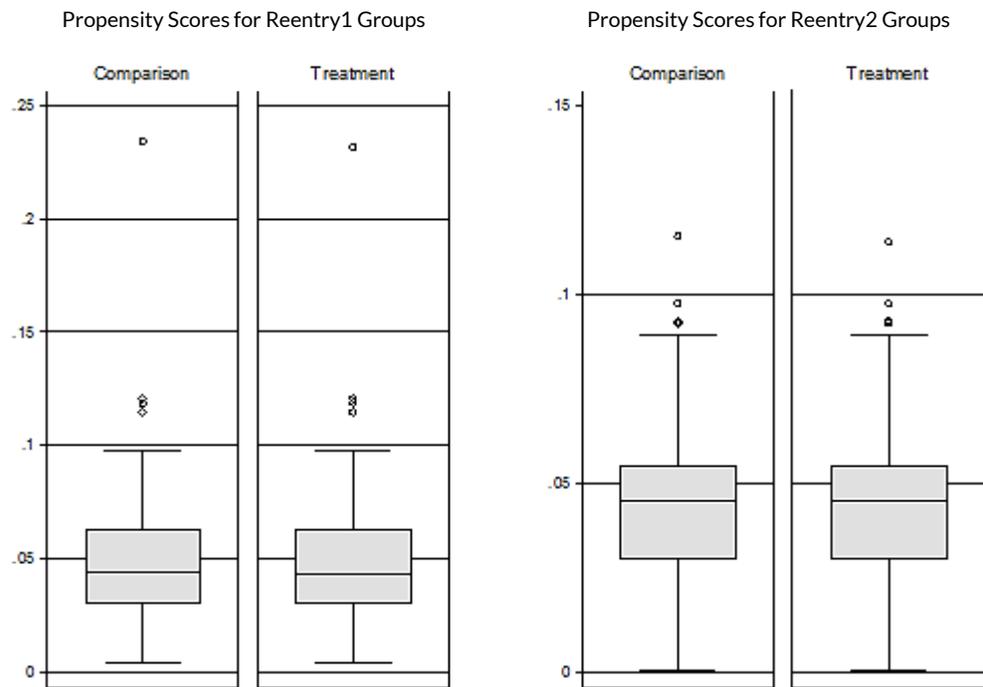
Note: Propensity score matching was performed based on 1:1 nearest neighbor matching with a caliper of 0.01, a common support requirement, and no replacement.

The propensity score matching procedure achieved the balance between treatment (i.e., Reentry program participants) and comparison groups overall and on selected variables of substantive interest. Figure 3 shows the distribution of the propensity scores for Reentry1 and Reentry2 clients and their respective comparison groups. The comparison and treatment groups have nearly identical distributions of propensity scores for both Reentry1 and Reentry2 programs, indicating excellent matching performance.

Additionally, although the average propensity score is similar between Reentry1 and Reentry2 groups, the distributional characteristics of Reentry1 and Reentry2 groups are somewhat different. Comparing recidivism outcomes between the Reentry1 and Reentry2 programs would therefore require caution—this was another reason that impact analysis did not compare the effects of Reentry1 and Reentry2 against each other.

FIGURE 3

Propensity Score Boxplots by Treatment Status



Processing of Jail Records

To evaluate the effect of the Reentry1 and Reentry2 programs on future involvement in the criminal justice system, the research team examined whether individuals had subsequent jail admissions. We first identified a final set of jail release dates to use as the “anchor date” for measuring recidivism outcomes. The anchor date was the jail release date after which any further criminal offending would be counted as recidivism. For the Reentry1 and Reentry2 groups, the team used the jail release date following their Reentry program start date. For the comparison group, the research team considered two approaches for determining an anchor release date: the release date in closest proximity to the Reentry program start date in absolute terms, and the release date in closest proximity following the program start date.²⁵ Appendix A details the analytical considerations and limitations of each approach.

Creating the Weighted Sample

An important observation emerging from the construction of these groups was that some of the comparison individuals were drawn from the pre-Reentry program period, which has critical methodological implications for this study: comparison individuals were in the community for a longer period of time, and thus had more opportunity to reoffend, than Reentry program participants. Because of this increased time in the community, comparison individuals could have a higher recidivism rate than Reentry program participants only because they had been out of jail longer and had more opportunities to reoffend. This unavoidably resulted in complications with the treatment and comparison groups, compromising the balance between the treatment and comparison groups achieved through PSM.

The impact analyses addressed this issue by developing an analytic weight that rebalanced the treatment and comparison groups on key variables, as well as on the exposure time to the risk of recidivism. The construction of this weight is through a statistical technique called a maximum entropy reweighting. Simply put, this adjustment strategy aims to achieve equivalence between treatment and comparison groups based on a given set of variables. Table 2 on the following page demonstrates that this process resulted in treatment and comparison groups that are strongly comparable on key criminal and demographic indicators for both the Reentry1 and Reentry2 programs.

Analysis Methods

Logistic regression and Kaplan-Meier survival curves were employed to analyze the effect of the Reentry1 and Reentry2 programs using these treatment and comparison groups. Logistic regression is used to predict the likelihood of rearrest and investigates the influence of the Reentry1 and Reentry2 programs on this likelihood.

TABLE 2

Final Reentry1 and Reentry2 Groups and Comparison Groups

	Reentry1	Reentry1 Comparison	Reentry2	Reentry2 Comparison
Gender (male)	93%	93%	85%	83%
Avg. age (years)	31	32	30	29
Race				
White	39%	38%	42%	41%
Black	60%	61%	58%	57%
Other	1%	1%	-%	2%
Marital status (single)	73%	74%	80%	79%
Proxy risk				
Low	9%	10%	5%	6%
Medium	43%	35%	46%	47%
High	48%	55%	49%	47%
Avg. jail length of stay (days)	378	383	311	314

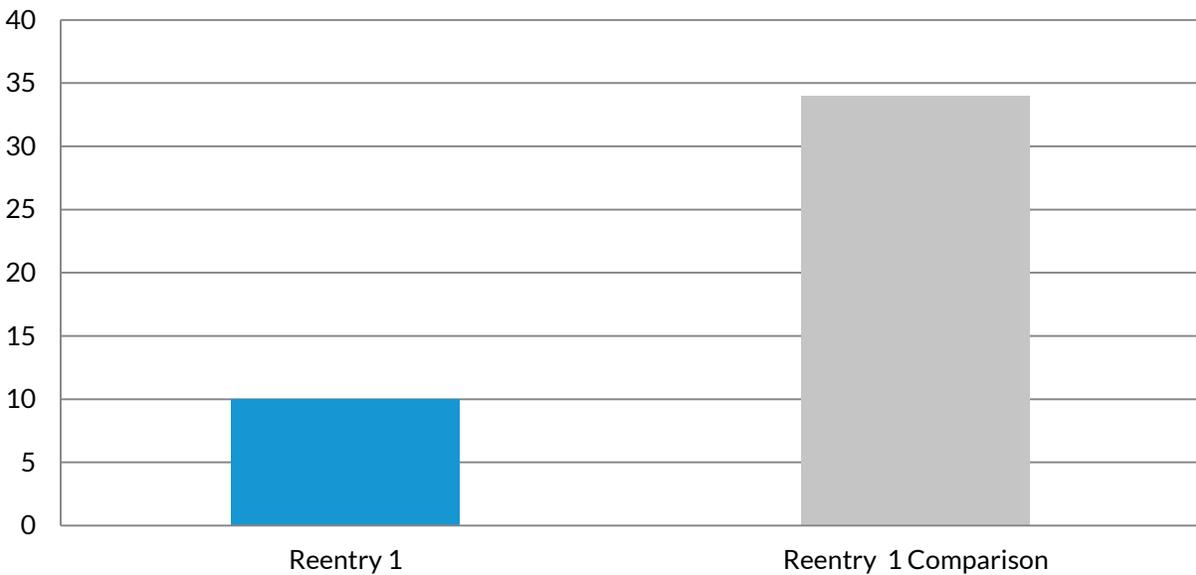
Kaplan-Meier curves reflect the proportion of offenders who are not returned to jail over time. These curves are one of the most widely used methods to examine a recidivism rate, survival rate, or drop-out rate for different lengths of time, while considering exposure to risk; they are used in this report to estimate the likelihood of recidivism over time for Reentry1 and Reentry2 samples. Because the likelihood of recidivism is linked to the amount of time a program participant spends in the community, the amount of exposure to risk (street time) is taken into consideration in this analysis.

Reentry1 Impact Results

Findings from this analysis indicate that the Reentry1 program reduces the probability of future rearrest by 24 percentage points. Controlling for individual characteristics, the Reentry1 program participants have a 10 percent chance of being rearrested, while their counterparts have a 34 percent chance. This difference between the two groups is statistically significant (figure 4).

FIGURE 4

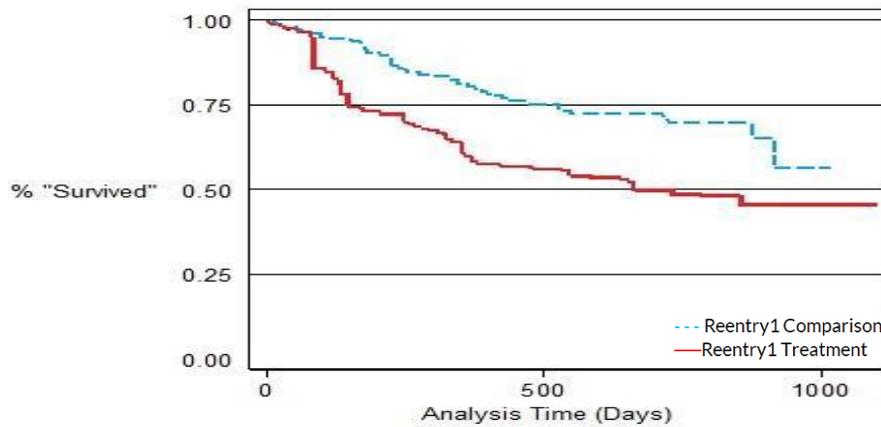
Probability of Rearrest



These findings are corroborated by the analysis of the Kaplan-Meier curve for the Reentry1 program. The Kaplan-Meier curve (figure 5) indicates that the Reentry1 program prolongs clients' time to rearrest. This finding is particularly pronounced 90 days *after* release from jail: at 90 days, 5 percent of the treatment group and 14 percent of the comparison group were rearrested; at 180 days, 10 percent of the treatment group and 27 percent of the comparison group were rearrested; and at 360 days, 20 percent of the treatment group and 40 percent of the comparison group were rearrested. These findings are statistically significant. This finding supports the Reentry1 program's logic that continued support post-release assists with client stability.

FIGURE 5

Kaplan-Meier Survival Curve (Reentry1)

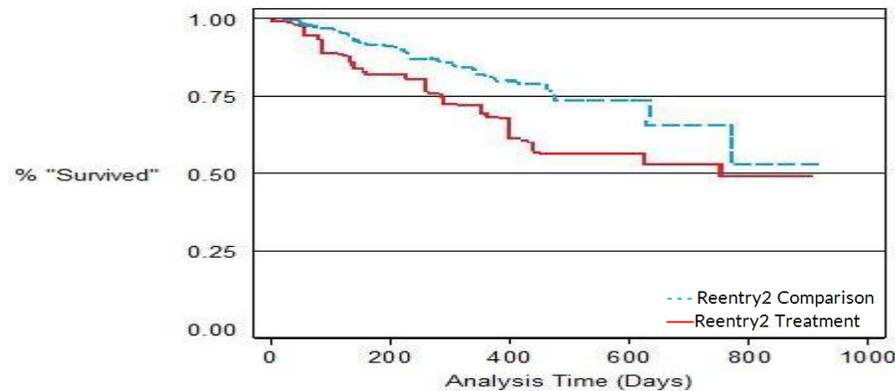


Reentry2 Impact Results

While impact analysis suggests that the Reentry2 program reduces the probability of rearrest, this finding only approached statistical significance ($p = 0.056$). An analysis of the Kaplan-Meier curve, however, finds statistically significant evidence that the Reentry2 program prolongs time to rearrest (figure 6). Similar to the Reentry1 program, these effects are particularly pronounced 90 days *after* release from jail but hold throughout.

FIGURE 6

Kaplan-Meier Survival Curve (Reentry2)

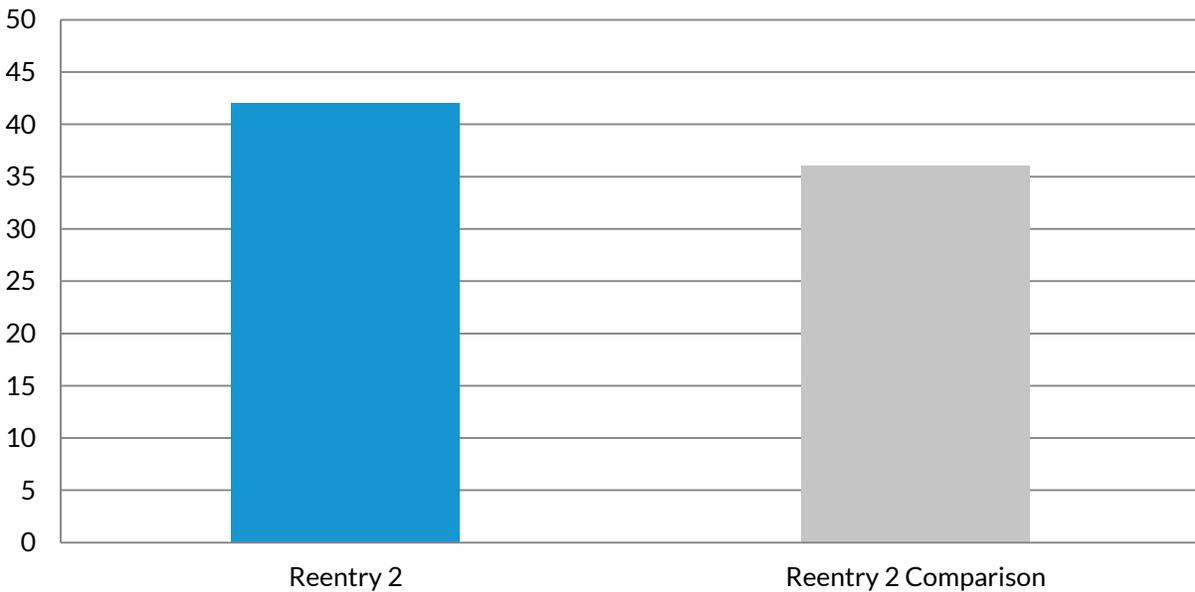


Given the important role of probation officers in the Reentry2 program model, the impact analysis also investigated the program's effect on probation supervision violations. An analysis of probation violation rates found that rates of probation violation of Reentry2 clients and their associated comparison group were similar, with a slightly larger percentage of Reentry2 clients (42 percent) having a probation violations than their associated comparison group (36 percent) as indicated in figure 7.

FIGURE 7

Reentry2 Probation Violations

Percent of group with probation violations



Summary of Impact Analysis Findings

Impact analyses, while limited, suggest that both Reentry1 and Reentry2 reduce rearrest among participants and prolong time to rearrest after the first 90 days post-release, indicating that initial and continued program efforts to stabilize clients are effective. While Reentry2 clients had a greater number of probation violations than their comparison group, this finding could be a result of the increased supervision of probation clients that occurs as a standard part of the Reentry2 program.

Section 5. Summary of Findings

There is solid evidence that Allegheny County's Second Chance Act reentry programs reduce recidivism. The impact analysis ($N=798$) found that participation reduces the probability of rearrest by 24 percentage points for those involved in Reentry1 (i.e., the Reentry1 group had a 10 percent probability of rearrest while the comparison group had a 34 percent probability); this finding is statistically significant. Likewise, Reentry2 participants were less likely to be rearrested than the comparison group, however, this finding only approached statistical significance ($p=0.056$). Program participation had little effect on supervision violations for the Reentry2 group. The programs' impact on reconviction and returns to custody could not be measured.

Findings of program impact are supported by ample evidence of implementation fidelity and practices aligned with principles of effective intervention (Domurad et al. 2010; Matthews et al. 2001). For example, both programs target offenders at medium- to high-risk for reoffending; review of 76 case files (31 Reentry1, 45 Reentry2) suggests both programs are hitting this mark: 92 percent of Reentry1 cases and 95 percent of Reentry2 cases reviewed scored as medium- to high-risk for recidivism. Additionally, 97 percent of Reentry1 cases had recorded risk/needs assessments and 100 percent of those cases with recorded MoCo assessments also had required Phase 1 reentry plans; 63 percent of those cases eligible to have both Phase 1 and 2 case plans, did so. In turn, 86 percent of the Reentry2 cases reviewed had recorded LSI-R risk/needs assessments; Offender Service Plans were common in the Reentry2 case files.

While needs matching was more challenging to reliably assess, due in part to the structure and content of program case files, the available data do indicate widespread use of designated programs and services. Importantly, in actuality, cognitive behavioral interventions appeared to be a core program component: nearly 68 percent of Reentry1 program participants received *Thinking for a Change*. The research clearly supports the centrality of cognitive behavioral interventions to recidivism reduction (see, for example, Lipsey et al. 2007). Lastly, both program models emphasize prerelease contact between inmates and key supports—that is, Reentry Specialists (Reentry1) and designated POs (Reentry1 and Reentry2). The fidelity assessment found high compliance with these aspects of the model in both programs, but was easier to measure and substantiate for Reentry2. Under Reentry2, 84 percent of cases met with their designated POs before release (range spanned 1–8 contacts) and 75 percent had multiple contacts (2 to 14) in the community post-release.

Section 6. Recommendations and Action Steps

Consistent with the evaluation's objectives, Urban-JPC researchers close this report by offering a number of recommendations for continued program improvement based on review of the core correctional practices literature, fidelity assessment results, and stakeholder and client input. As discussed, the ACJC and its partners had already begun acting on several of the study's initial recommendations and incorporated several, as discussed below, into the reentry program's redesign (June 2013 program correspondence; ACJC Annual Report 2013).

The modified reentry program strategy (1) prioritizes cognitive behavioral interventions and career-oriented vocational training as central components of its reentry approach; (2) streamlines the structure of reentry services by bringing case management and oversight of reentry supports (i.e., four CSCs and two Reentry Coordinators) under the leadership of the ACJ's Reentry Administrator; (3) enhances the case management-PO collaboration established under Reentry1 by pairing CSCs and designated POs (similar to Reentry2) to form geographically based teams that coordinate client services and monitor compliance; (4) continues to work with families through the CSCs, who will receive specialized training in family support strategies; and (5) focuses reentry planning and preparation on the 60 days before an inmate's release and narrows intensive post-release reentry support to the six weeks following release with additional support provided as needed for five to nine months after release. Several of these changes had been implemented as of February 2014, when Urban-JPC researchers presented the study's findings to the ACJC and its partners.

Reentry Practices

- **Conduct universal risk screening.** Screening for risk of reoffending is a foundational tool to quickly sort criminal justice populations and determine which require in-depth assessment to identify which needs to address to reduce the likelihood of reoffending (Christensen et al. 2012). While screening became more routinized over time (100 percent of Reentry1 clients in 2012 had recorded scores), just 38 percent of the 2013 Reentry1 cases available for analysis (5 of 13) had risk scores. Given risk screening's fundamental role in properly triaging and intervening with offenders, Allegheny County should strive to routinely screen its criminal

justice population for risk-to-reoffend, use that information to allocate assessment resources, and share risk scores with partners to reinforce risk-based (as opposed to offense-based) decisionmaking and intervention.

- **Implement an automated, scored actuarial risk/need assessment across key partners.** *In process.* At the end of the study's observation period (August 2013), plans to move forward with the design and validation of a local risk/needs assessment (for use across criminal justice and human services partners) were in place and initial data collection had begun under the county's Justice Reinvestment Initiative.
- **Re-assess reentry clients at established intervals and incorporate results into reentry and supervision plans.** As discussed, clients should be regularly reassessed, consistent with the principles of effective intervention, to measure progress and adjust services and treatment as needed (Matthews et al. 2001; Gendreau et al. 2004; Domurad et al. 2010). Reassessment may take place at three- or six-month intervals (Genreau et al. 2004: 27). Results should be reviewed to detect changes in dynamic factors and assessed in light of the offender's level of compliance to inform both service planning and supervision responses (Casey et al. 2011).
- **Establish a sanctions and incentives structure.** To ensure reentry staff, particularly POs, are properly positioned to reinforce positive behavior change and respond to noncompliance, Adult Probation should design and implement a standardized system of incentives and sanctions (Fabelo et al. 2011).
- **Review and monitor core processes regularly.** Reentry leaders should regularly review and monitor core processes such as screening, assessment, and case planning to ensure these processes are being implemented as intended and to identify areas for correction or modification.
- **Develop performance metrics, compile and review regularly with ACJC partners and program staff.** Related to the previous bullet, developing, compiling, and reviewing performance data on key processes is essential to proactively monitor and manage program operations.
- **Continue probation/case management pairing.** *In process.* Program modifications, as discussed at the beginning of this section, not only retained a collaborative PO/case manager structure but enhanced it by formalizing the pairing as geographically-based services and supervision teams. Both staff and clients viewed the collaborative structure of the Reentry1 program

positively, identifying benefits for staff as well as clients (e.g., better information-sharing and more coordination).

Reentry Programming

- **Prioritize cognitive behavioral interventions.** *In process.* Under the ACJC's revised reentry programming approach, *Thinking for a Change* will be the first class scheduled for clients as it provides the foundation for addressing distorted thinking, antisocial attitudes and reactive decision-making. The capacity of cognitive behavioral interventions, like *Thinking for a Change*, to reduce the likelihood of reoffending is well-substantiated (Lipsey et al. 2007; Pearson, et al. 2002; Wilson et al. 2005) and widely viewed as a core component for rehabilitation and recidivism reduction.
- **Advance a career development approach and expand apprenticeship options.** *In process.* A common theme across client focus groups was the need for additional employment resources, particularly those that could provide career-oriented training and skill development (i.e., a sustainable job path with the potential for growth and to earn a living wage), as opposed to a "dead-end" job that might meet an immediate need. Clients appreciated apprenticeship programs like Springboard Kitchen but encouraged development of apprenticeships in other career areas. Like *Thinking for a Change*, the ACJC's modified reentry program approach will prioritize the county's new Career Tech classes. Career Tech provides clients with hands-on training and the opportunity to earn nationally-recognized credentials to embark on careers in machining and other types of skilled trades.
- **Continue probation prerelease contacts.** *In process.* Probation staff appreciated the opportunity afforded under the Reentry1 and Reentry2 programs to regularly access clients in the jail; POs reported that it allowed them to build rapport with clients and set expectations. Likewise, many program participants credited the prerelease contacts with their PO with imparting a helpful sense of what would be required of them while on post-release supervision; several clients felt well-prepared for this aspect of reentry.
- **Continue to develop housing options.** *In process.* Reentry program participants cited housing resources as a critical reentry need, and many credited the Reentry1 and Reentry2 programs for connecting them to housing. However, some clients reported having to go through lengthy processes to access housing, while others suggested that not enough housing options existed.

In response, the ACJC and its partners have prioritized development of alternative housing options under the reentry program redesign as stakeholders recognize the critical stabilizing effect that access to safe and drug-free housing affords clients returning to the community from jail.

- **Continue provision of bus passes/tokens.** *In process.* Focus group participants consistently reported that the provision of bus passes was a critical component of the Reentry1 program as it made it easier for them to meet various commitments upon release, including treatment and supervision appointments. Reentry2 focus group participants also highlighted the importance of transportation, but primarily because so many did not have access to reliable transportation (bus passes were not a standard component of Reentry2). The ACJC will continue to provide transportation assistance through the CSCs and reentry POs.
- **Improve family member knowledge of services and program.** As discussed, many family member focus group participants were unfamiliar with the range of family support services available to them through family support services. Many reported being connected to family support services through Amachi. Program leaders should develop an informational card or packet for distribution to family members that explains both the range of reentry services available to their incarcerated loved ones and those available to family members.

Quality Assurance

- **Develop and implement a quality assurance plan.** Quality assurance (QA) provides a mechanism by which to objectively and routinely examine practices and procedures to determine how well transition components are being conducted (Buck Willison et al. 2012). Stakeholders should develop a QA plan that clearly outlines key processes and procedures under the redesigned reentry program²⁶ and determine who will be responsible for periodic review of various processes and procedures, and to whom the results of this review will be reported. Additionally, the QA plan should also address service delivery and fidelity to selected curricula.
- **Convene a QA workgroup.** The ACJC should consider convening a quality assurance workgroup composed of program and partner staff and supervisors to develop an initial QA plan and timeline for implementation, and to oversee the actual QA process.

- **Track service utilization and dosage.** Stakeholders should establish mechanisms to monitor whether programming and service dosage approach and/or meet the recommended thresholds necessary for recidivism reduction as outlined in the literature: 300 hours for high-risk individuals; 200 hours for moderate- to high-risk individuals, and 100 hours for moderate risk individuals (Carter and Sankovitz 2014) over a three to nine month period (Matthews et al. 2001). Delivering interventions at the specified dosage and level of intensity is critical to improved reentry success, including recidivism reduction.
- **Design and implement performance metrics.** Basic performance measures to track key processes, outputs, and outcomes (short and long term) should be developed, compiled, and reviewed on regular basis (i.e., monthly or quarterly depending on information needs). Allegheny County has tremendous data and analytic capacity, much beyond many other jurisdictions. Collecting and analyzing performance data will allow the ACJC and program partners to monitor operations, measure progress, and determine where modifications may be needed. Performance metrics should include intermediate outcomes, not just end outcomes (i.e., recidivism, employment, and so on). As an example, stakeholders could track reentry pod outcomes (disciplinary incidents), in keeping with the hypothesis that the Reentry Pod might have fewer serious disciplinary incidents, such as fights, than other pods in the jail. Such data can make a compelling case regarding the importance of specialized housing units and a reentry approach.
- **Standardize case files and reporting.** Standardizing the contents and structure of case files will enhance the likelihood that crucial information is routinely documented and available for review. A checklist that identifies key case file components could facilitate this consistency.

Training

- **Develop and implement standard reentry training for program and partner staff, particularly those tasked with case management function.** Staff consistently identified a need for formal training, particularly around program operations and procedures. The ACJC should consider developing a basic training curriculum that clearly describes staff roles and responsibilities, documents critical program components, and discusses key processes and their administration. Doing so will equip staff and increase the likelihood that critical processes will be implemented with fidelity despite changes in staff.

- **Train on core correctional practices.** Training both program and correctional staff (Reentry Center and Reentry Pod officers) on the core correctional practices outlined in this report will not only increase staff knowledge but will also facilitate a shared understanding of reentry objectives, promote the use of practices associated with positive reentry outcomes, and ultimately cultivate a cross-systems culture supportive of reentry.
- **Train on core curricula and monitor fidelity.** There should be close oversight of reentry programming for current and former inmates to ensure fidelity to designated program curricula and service protocols. Staff charged with quality assurance monitoring should be familiar with, if not trained on, the specifics of program curricula and should periodically observe program and treatment sessions to monitor implementation fidelity and identify areas for corrective action. Staff charged with delivering various program curricula should be fully trained with a demonstrated proficiency in program facilitation. Booster trainings should be provided to ensure staff skill levels are maintained.

In closing, it is important to note that this evaluation found strong and credible evidence that Allegheny County's Second Chance Act reentry programs reduce recidivism as measured by rearrest. These findings are not surprising given the programs' clear adherence to principles of effective intervention. The recommendations and action steps outlined above offer ACJC stakeholders a map to further strengthen reentry programming and increase the likelihood of successful reentry for Allegheny County inmates.

Appendix A. Constructing Anchor Dates: Limitations and Considerations

The research team considered two potential strategies for assigning a release date. The first option was to select the earliest jail release date after the associated reentry program start date,²⁷ recognizing that programs start while the Reentry1 and Reentry2 groups are still in the jail. For example, if an inmate in the Reentry1 comparison group had jail release dates on June 1, 2010 and August 8, 2010, the June 1st date would be chosen under this approach because in absolute terms it is closest to the start of the Reentry1 program (i.e., June 22, 2010).

The second strategy considered was to take the nearest jail release date that occurred after the start off the associated Reentry program. Referring to the example above, this would mean that the date of August 8, 2010, would be selected as the release date for when a comparison group member was released in to the community (i.e., to start the measurement “clock”). This approach was utilized in this research given its thematic consistency—clients in the actual Reentry1 and Reentry2 programs could only be released after their connection to the program, and using a proximate release data after program entry for comparison group clients replicates this timeline.

In processing these release dates, a number of anomalies surfaced that forced a reevaluation of the sample design. First, it was found that there were no jail records for 31 people from the core dataset, 15 of whom were Reentry1 comparison individuals and 16 Reentry2 comparison individuals. These individuals had to be removed from the dataset.

Second, there were more than 6,000 jail records appended to our samples in the core dataset, and some of those data points were beyond the expected range or had no valid date. In the Reentry1 and Reentry2 treatment groups, a total of 52 individuals were removed from the sample because they had no release date and there was thus no recidivism to measure. In the Reentry1 and Reentry2 comparison groups, a total of 121 individuals were removed from the sample: 6 Reentry1 and 2 comparison group members had no release dates and 115 individuals’ contact with the justice system occurred too far in the past to make a comparison viable. These removals resulted in a total sample of 798 individuals for analysis.

This data loss might have been prevented during the initial process of constructing the matched comparison groups if recidivism measures were available for the entire pool of potential comparison subjects. However, it was prohibitively labor intensive to compile such information for a large volume of

cases (n ~ 10,000) at the outset of our analysis, and the research team proceeded with the construction of matched comparison groups, with intention to append that information subsequently for the finalized set of treatment and comparison cases. However, there were considerable challenges in linking administrative records, which resulted in non-trivial data loss and statistical adjustments.

An important observation emerging from the construction of these groups was that some of the comparison individuals were drawn from the pre-reentry program period, which has critical methodological implications for this study: comparison individuals were in the community for a longer period of time, and thus had more opportunity to reoffend, than reentry program participants. Because of this increased time in the community, comparison individuals could potentially have a higher recidivism rate than reentry program participants only because they had been out of jail longer and had more opportunities to reoffend. This unavoidably resulted in complications with the treatment and comparison groups, compromising the balance between the treatment and comparison groups achieved through PSM.

Notes

1. With an action research approach, researchers work closely with program partners to monitor implementation and refine program operations based on early and frequent feedback from the evaluation.
2. Initially conceived as a 12-month evaluation spanning August 2012 to July 2013, the study's scope and timeline shifted considerably in November 2012 when its sponsors expanded the focus to include the Reentry2 program. Ultimately, the study was extended to June 2014 to permit additional data collection (family member focus groups in August 2013) and efforts to address the vagaries of the administrative data.
3. Convened in 2000, the ACJC consists of key leaders and stakeholders from across the county's criminal justice, human services, and civic spheres, including: judges; court administrators; directors of probation, health, and human services; jail administrators; staff of the county executive; service providers; and local foundation leaders. The ACJC meets monthly to advance its two primary goals: increased public safety and reduced recidivism (2013 ACJC Annual Report; <http://www.alleghenycounty.us/dhs/jail.aspx>).
4. The Proxy generates a score for risk of reoffending based on three data points: current age, age at first arrest, and number of prior offenses. Scores fall along an eight-point scale (2–8), with a higher score indicating a greater likelihood of recidivism; scoring ranges are determined based on the distribution of data for the specified local population (i.e., in this instance, jail inmates) with cut-points based on how the population falls into thirds. For more information on the Proxy, including its predicative capabilities and scoring, see Bogue, Woodward, and Joplin 2005; for more information about the role of risk screeners in reentry triage and transition planning, see Christensen, Jannetta and Buck Willison 2012.
5. If an eligible inmate had already been placed in alternative housing, a Reentry Specialist would meet with the inmate at his/her alternative housing location to present the program. If the inmate agreed to participate, a risk/needs assessment would then be conducted and a Phase 1 plan developed to identify goals and reentry needs; the Reentry Specialist would also meet with the client while in alternative housing to work on transition preparation.
6. These 25 cases were excluded from both the fidelity assessment and impact analysis. Reasons for ineligibility ranged from the client moved out of the area (one-third of these cases) to case transfer, early release, not sentenced, electronic monitoring, and death.
7. Examples include a client that cannot be located or who is not actively working toward his or her reentry plan goals (Allegheny County Reentry Program Manual 2012).
8. With the hiring of a Reentry Pod Coordinator in fall 2012, the unit became fully functional.
9. Gender was missing for two cases.
10. A mid-January 2013 teleconference briefed stakeholders on themes from Urban's first two site visits and an initial set of jail- and community-based client focus groups with Reentry1 (Phase1) and Reentry2 participants conducted November 28–30, 2013. In February 2013, Urban-JPC researchers conducted an on-site briefing with a selected set of ACJC stakeholders to discuss themes emerging from the team's February stakeholder interviews and Reentry1 (Phase 2) client focus groups, and the memorandum commissioned by the ACJC the prior month regarding research and resources on six topics: (1) offender motivation as a factor for prioritizing program participation and common measures of offender motivation; (2) evidence-based treatment programs with cognitive behavioral components; (3) employment services and programming that focus on career development; (4) models of probation and community services partnerships, specifically the Opportunity to Succeed Model; (5) models of family case management; and (6) trauma curricula used in a jail setting. Urban submitted this memo to the ACJC on February 8, 2013. Additional briefings were held in June 2013 and February 2014; the ACJC also received memos summarizing focus group findings in December 2012 and February 2013, in conjunction with the ACJC's annual planning process.
11. As consulted February 6, 2014.
12. Auglaize County Transition Program (Miller and Miller 2010); Boston Reentry Initiative (Braga et al. 2009); Center for Employment Opportunities (Redcross et al. 2012); ComALERT (Jacobs and Western, 2007); Challenge to Change Therapeutic Community (Sacks et al. 2012); EQUIP (Liau et al. 2004); Florida Work

Release (Johnson 1984); Prison Industries (Johnson 1984); and Project Greenlight (Wilson and Davis 2006). For study details see <http://whatworks.csgjusticecenter.org/search>

13. It has been noted that practitioners and researchers would do well to keep in that mind that fidelity and quality are separate concepts, and should be treated as such. Fidelity should be considered with reference to a proven intervention—that is, whether rigorous replication yields the same results as earlier testing—while quality considers the characteristics or essence of something. Having one is not always indicative of the other: a program may be implemented with fidelity, but be of poor quality. Ostensibly, high-performing interventions must be high-quality and delivered with fidelity.
14. The focus group at DRC East involved six participants, while the second focus group, conducted at the Day Reporting Center South, consisted of nine participants.
15. The first family member focus group had six participants. The second group, conducted two months later, had 10 participants, but 4 had participated in the prior group, thus reducing the number of unique participants to 12.
16. The original dataset included 341 discrete Reentry1 clients, but 25 were deemed ineligible for the program after intake and were removed from the current analysis. This resulted in a final dataset of 316 discrete clients. Additionally, two clients were enrolled in the program twice. Because the objective of the analysis was to focus on clients rather than enrollments, the second outcomes of each of these clients were not analyzed.
17. The first program enrollment recorded in the Reentry1 program database is on 6/22/2010, with the last enrollment recorded 2/8/2013. The first recorded release from jail is 9/20/2010 and the last recorded release is 2/13/2013. The first exit from the program occurred on 9/21/2010 when a client withdrew from the program, and the final exit occurred on 2/14/2013 because the client had a warrant. This end date is also the last chronological piece of information recorded in the dataset accessed by Urban-JPC researchers for this analysis.
18. To answer the third research question, Urban-JPC researchers analyzed program data on 316 Reentry1 clients in order to construct and examine profiles of client needs and services relative to program outcomes. This analysis could only be performed with Reentry1 clients as comparable automated data did not exist for Reentry2 program clients.
19. Kaplan-Meier curves are a widely accepted method for determining risk over time, and were used to determine the effect of the Reentry1 and Reentry2 programs on time until recidivism.
20. Urban defined Phase 1 of the Reentry1 program as lasting from the client's enrollment into the program to the development of their Phase 2 service plan. Phase 2 lasted from the creation of the Phase 2 service plan to the client's end in the Reentry1 program. This means that in some cases, if a client never received a Phase 2 service plan, they would be considered "in Phase 1" for the whole tenure of the program for purposes of the analysis.
21. These include *Thinking for a Change*, family support, parenting classes, job readiness, job search assistance, GED classes, Alcoholics Anonymous, Narcotics Anonymous, ACHS drug and alcohol services, and ACHS mental health services and lifeskills classes.
22. As discussed later in this report, analysis did not find any evidence that either Reentry1 or Reentry2 routinely reassess clients in order to monitor progress around dynamic needs factors consistent with evidence-based practices.
23. Initially, the Reentry2 program specified that its designated POs would meet with clients a few days before release (Allegheny County Adult Probation and Parole SCA proposal 2011); by September 2012, the program's POs reported meeting with inmates monthly to monitor progress and engage in additional planning.
24. This activity was reportedly being scaled back (as reported at the end of the evaluation period) because of funding restrictions.
25. The reason for this debate was that the comparison groups had to be evaluated starting from a release date, but they did not have a program entry date that could be used to determine which of their releases from jail was most suitable for this purpose.
26. The Reentry1 Program Manual may serve as a helpful template with respect to identifying key processes and related benchmarks.
27. June 22, 2010, for Reentry1; December 1, 2011, for Reentry2.

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The Jail Inreach Project: Linking Homeless Inmates Who Have Mental Illness With Community Health Services

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The Jail Inreach Project is a health care–based intensive case management “inreach” program that engages incarcerated persons from the homeless population who have behavioral health disorders (mental illness, substance use disorder, or both) in establishing a plan for specific postrelease services. The Jail Inreach Project aims to provide continuity of care and integrate this highly marginalized subpopulation of homeless persons into primary and behavioral health care systems by establishing patient-centered health homes. The use of integrated primary and behavioral health models in conjunction with provisions for immediate access to and continuity of care upon release is emerging as a best practice in combating the rapid cycling of this vulnerable population between streets and shelters, emergency centers, and the county jail. Preliminary results indicate that more than half of the persons referred to the program remained successfully linked with services postrelease, whereas slightly less

than one-third who engaged in services while incarcerated did not retain linkage on release. (*Psychiatric Services* 62:120–122, 2011)

Abrupt termination of care is a devastating consequence of a correctional system’s inability to coordinate and link released inmates with behavioral health and social services. In 2007 an estimated 79,000 adults with serious mental illness were unable to access community-based public or private mental health services in Harris County, Texas (1). As a result, the Harris County Jail has become the de facto primary mental health care provider for the county. It serves as the largest provider of mental health beds in Texas and the second largest such provider in the nation (second only to the Los Angeles County Jail) (2).

There are roughly 2,400 people using mental health services in the Harris County Jail on any given day (2). In the absence of proper linkages to necessary behavioral health and social services, many members of the mentally ill homeless population cycle between the streets and shelters, emergency centers, and jail cells in a virtual revolving door, and the costs to the county attributable to their increased rearrest rates exceed \$14 million per year. This column describes an emerging best practice—the Jail Inreach Project—to address the mounting implications of disruption or termination of care for persons who have been released from jail and are mentally ill and homeless.

The Jail Inreach Project

The Jail Inreach Project in Harris County, Texas, provides services that strive to improve health status, support social reintegration, and reduce the costs and overall burden on the public health care system of persons who are mentally ill and homeless and being released from the Harris County Jail. In 2006 the Jail Inreach Project was established and locally funded as a demonstration project under the auspices of Healthcare for the Homeless–Houston (HHH). The Jail Inreach Project provides continuity of and access to integrated primary care and behavioral health care (mental health and substance abuse treatment) services upon release for Houston’s homeless population with mental illness, who rapidly cycle through the Harris County Jail. It further provides a replicable model of care that addresses the underlying causes of increased rearrest rates and the immediate need for services after incarceration.

The program aims to reduce rearrest rates and combat the rapid cycling of the mentally ill homeless population through Harris County Jail; to collaborate with the Harris County Sheriff’s Department and the local public mental health agency to develop a more coordinated system of care that supports homeless releasees in accessing resources; and to facilitate the transfer of medical records between the Harris County Jail, community-based clinics, and the public health care system to improve communication and coordination between health care providers.

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Program design

HHH and the Mental Health Mental Retardation Authority (MHMRA) of Harris County met for the first time in early 2006 to solidify collaboration on the Jail Inreach Project. The meeting led to a memorandum of understanding between HHH and MHMRA that established a referral process, which allows HHH case managers to initiate contact with Harris County Jail inmates with mental illness who were homeless at incarceration or are anticipated to be homeless on release and to create a system for sharing patient records to enable continuity of care and streamline research and evaluation efforts. The memorandum further designated the placement of a licensed MHMRA clinician within HHH clinics, marking the first time that MHMRA had achieved such a placement within a Harris County federally qualified health center.

Evaluations and assessments are performed by staff while the client is still incarcerated, and linkages for needed services are established. In meeting with an inmate before his or her release, the goal is to identify the needs of the individual and to develop a discharge plan that includes initial medical and behavioral health care (including psychiatry, as needed) provided by HHH, eligibility assessments for MHMRA services, substance abuse assessment and counseling provided by HHH, and an assessment of housing and transportation needs and benefits eligibility.

In order to maximize the effectiveness of the discharge plan, case managers provide clients with the option for a "direct release" into the care of a case manager. This means that rather than being discharged from the jail to one's own care in the middle of the night (as is standard practice), participants may choose an escorted release if they agree to stay in jail until the following morning. Individuals who volunteer for daytime release are met outside the jail by an HHH case manager, who walks them to HHH's Cathedral Clinic, located just blocks from the jail. At the clinic, they receive immediate health care. Individuals with serious mental illnesses and who therefore meet diagnostic criteria (have bipolar disorder, schizophrenia

or schizoaffective disorder, or major depression) may be eligible for services via the public mental health system. Access to the public system of care often requires weeks to months on a waiting list for an appointment, during which time patients might relapse because of a lack of access to medication. HHH often provides interim care until those who are eligible can be linked into larger public systems of care.

Participation in this program is based on the following four criteria. Participants must be detained in Harris County Jail; have a diagnosis of a behavioral health condition (mental illness, substance use disorder, or both); anticipated to be homeless upon release; and have a history of recidivism, defined as having had two or more bookings into Harris County Jail in the previous six months.

Preliminary findings

As of June 26, 2009, when the initial program evaluation began, 492 individuals had been referred to the Jail Inreach Project. Twenty-two percent experienced multiple encounters (those who are rearrested are contacted again by the program to try to link individuals back into community health services). For those who had multiple encounters with the program (those who are rearrested are subsequently revisited by their case manager, and a new case is opened), only the first encounter was included in this analysis. This was done to control for the possible implications that multiple encounters with the program may have on outcome and because each encounter can result in a different disposition (linked versus not linked, for example). Of the total number of first encounters (N=492), 275 (56%) resulted in successful linkage to service after their release. Twenty-four (5%) declined services, 53 (11%) were transferred to another correctional facility, and 140 (29%) engaged in the program while incarcerated but did not follow through with the program on release.

A study was conducted by HHH in collaboration with MHMRA and the Harris County Budget Office that evaluated arrest rates one year before engaging in the program and one year after engagement. Results indicate that those who were linked to services after

their release had arrest rates that were 36% lower compared with the number of arrests one year before contact with the program and one year after contact with the program. Also, the average number of days spent in jail decreased from about 65 days before contact with a case manager to just less than 42 days during the year after contact with the program. Total annual criminal charges (misdemeanors and felonies) for each participant had also been reduced by 56% during the year after contact with the program.

Discussion

The delivery of health care in the correctional environment has many challenges. Those who are incarcerated and who have a behavioral health diagnosis tend to have more comorbid chronic medical problems much earlier than those who are not incarcerated. Because many detainees have poor health and inadequate diets, have risky lifestyles, and abuse substances, they are likely to have a higher incidence of medical conditions in addition to their mental health needs. Delivery of care within the jail and provision of discharge planning services are complicated by complex social and health needs, the usual short length of incarceration, and a sometimes uncertain date of release.

Many logistical considerations and adjustments had to be taken into account as the program developed early on; much time was spent experimenting with different procedures for visiting detainees in order to increase efficiency. Initially, detainees were called from their cells to an interview room on the first floor of the jail. The process of moving a detainee from his or her cell to the interview room often took up to 30 minutes. In the first six months, with over 85 referrals and nearly 200 visits, it became clear that a more efficient system was needed. We discovered that more detainees could be visited in a shorter period if the case manager went to the detainee's cell and met with him or her either in the cell or in another suitable location on the same floor. Similarly, the issue of dealing with uncertain release dates resulted in the development of a policy mandating that after the initial meeting, clients were seen only after

they had an established release date. This provision aided in successfully establishing a postrelease plan and in case managers' serving more clients because case managers could maximize the efficiency of how their time was allocated.

Outreach strategies that provide continuity of care have generally been supported as a best practice. The most effective strategies seem to be those that introduce personal connections and reduce the distinction between inpatient and outpatient services. Linkage is better served when the step to what has traditionally been called aftercare is treated more as a transition than as a change (3–5). Practices that include contact with the ongoing care agency before discharge have proven to be beneficial. For the Jail Inreach Project, the contribution of the negotiated direct daytime release to the care of a case manager cannot be overstated.

The most recent quality assurance analysis of the program indicated that 129 of 150 (86%) participants who opted for direct release to the care of a case manager were successfully linked to services, compared with only 51 of 181 (28%) of those who opted for a self-release. Further, those who opted for a "self" nighttime release were 6.2 times less likely than those who opted for a direct release to a case manager to be linked to services (6). Agreeing to spend a few more hours in jail in return for direct release may be an indicator of greater motivation for change but may also reflect the perceived importance of the health care and social service linkages provided by the program. Early indications from our data suggest that linkage, in its turn, appears to reduce the likelihood of rearrest, especially for participants with fewer and milder previous charges (misdemeanors versus felonies).

The importance of efficiently and effectively tracking client information and data in a way that is accessible to multiple HHH staff members, including case managers and administrators, as well as for research and evaluation purposes, led to the development of an online database, which is housed on a secure server at Baylor College of Medicine. It is used to track release dates, diagnoses, initial referral plans,

postrelease service linkages, and case status of the individual. The database can also generate reports for quality assessment and evaluation.

Conclusions

We believe that the design and implementation of the Jail Inreach Program constitutes a best practice that should be subjected to further services research. One of the most successful components of the Jail Inreach Project is in bridging gaps between services provided in the jail with services provided in the community. However, the program is restricted by the limited capacity of community resources to provide services after a detainee is released. An alarming shortage of affordable housing, psychiatric services, substance abuse treatment services, and other medical and social support services has put a ceiling on the capabilities of the safety net programs to benefit this population and the community at large.

Stemming from this assessment of the program, there are two subsequent evaluation projects examining whether there are differences in outcomes, procedures, or client characteristics between individuals who are linked to services and those who do not follow through with the program after release. Results will be informative in terms of tailoring better interventions and in replicating these findings.

On a systemic level, our findings suggest that effective and replicable mechanisms for reducing utilization of correctional institutions as behavioral health treatment facilities include offering early prerelease planning, engaging clients in their treatment plan, offering daytime release, and providing a full health evaluation, including medical case management and behavioral health assessments. These elements provide continuity of care for those who require medication and help to prevent lapses in treatment. In addition, the activation of social services (shelter and housing, job training, and life skills counseling) and health services (primary health home with behavioral health care) in the framework of enhanced integrated care appears to decrease arrest rates (thus decreasing utilization of mental health services within the correctional sys-

tem) and increase the possibility of transitioning out of homelessness.

Another opportunity for change in the collaboration between HHH and MHMRA would be to allow for integration of a behavioral health specialist in the primary health home. This would provide immediate behavioral health resources to stabilize clients adjusting to the challenges common to releasees. Clients could then be provided a permanent health home where their full health needs are addressed. Behavioral health exacerbations requiring internal referral or consultation could be obtained as needed. Future research will be necessary to validate our observations and recommendations.

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Appendix 7:
Housing Options for
Persons with MI in the
CJS

A Webinar-Supporting Document: Evidence-Based Practices and Criminal Justice Series

July 2015

Housing Options for Persons with Mental Illness Involved with the Criminal Justice System

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Homelessness is a pervasive issue for people in contact with the justice system and has a deleterious effect upon public safety. Housing instability and homelessness are common problems for persons with criminal histories and mental illness. In 1999, Nelson et al. found that parolees who stayed in shelters were seven times more likely to abscond from parole. Geller and Curtis (2011) found that men with incarceration histories were four times more likely to experience homelessness than men without incarceration histories. A study by McNeil, Binder, and Robinson (2005) of episodes of jail incarceration in San Francisco found that inmates who were homeless were more likely to have co-occurring disorders than non-homeless inmates. In addition, homeless inmates had an average length of stay 4.5 days greater than non-homeless inmates.

Evidence Base

The potential benefits of housing for justice-involved persons with mental illness, often called reentry housing, were first documented in a 2002 study of supportive housing in New York. That study showed a decrease of 22 percent in criminal convictions and 73 percent in days of incarceration for people placed into supportive housing while increasing for a comparison group (Culhane, Metraux, & Hadley, 2002). Subsequent efforts have worked to further refine targeting and quantify the impacts on public spending.



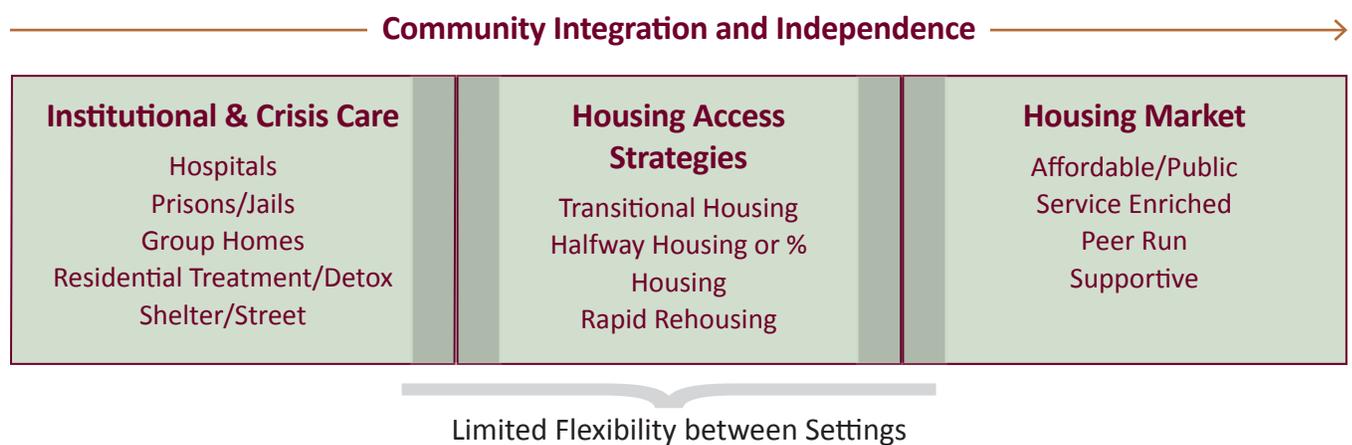
In New York City, the Frequent Users Services Engagement (FUSE) was one of the nation's first demonstration initiatives targeting people caught in a cycle of jail and homelessness through a data match to identify people with multiple stays in each system. A 2014 evaluation of the FUSE initiative showed that the program was successful in maintaining housing stability for 86 percent of tenants, reduced shelter costs by 94 percent and jail use by 59 percent (Aidala et al., 2014). Furthermore, the FUSE initiative generated an annual crisis care service cost offset of \$15,680, exceeding the \$14,624 in public investment in services, while saving over \$1,000 per person (Aidala et al., 2014).

In Los Angeles, the 10th Decile Project used service data to develop a predictive algorithm to identify people that are likely to be the most expensive in terms of publicly-funded crisis services (approximately \$6,000 per month while homeless) (Flaming, Lee, Burns, & Summer, 2013). Forensic involvement was determined to be one of the key predictive traits along with hospitalization and mental health hospitalization.

Community Integration and Independence

In the Community Integration and Independence model (see Figure 1), “Institutional and Crisis Care” represent the least integrated and independent settings including jails, residential treatment, hospitals, and homelessness. “Housing Access Strategies” are programs that offer time-limited supports with the goal of helping people access housing. They include traditional models such as halfway housing, transitional housing, and predominantly unregulated treatment and group housing. Regardless of model, their success is dependent on two factors: (1) increasing individual capacity so that people can access the broader housing market; and (2) adequate supply of appropriate housing upon exit. They are often located in specialized or licensed facilities, but can be structured as transition-in-place models that access community housing and reduce services and rental supports over time to minimize disruption. Ideally, these programs are targeted to people with low to moderate needs with the ability to quickly increase their income. “Housing” is the most integrated setting, encompassing a variety of models where residents are afforded normal tenancy protections and may have access to rental subsidy and services supports.

Figure 1. The Community Integration and Independence Model



Matching Housing Options with Individual Needs

Needs assessment is essential when designing an effective package of services for reentry housing. A person with low housing support needs may have a recent history of employment, a stable mental health condition, and a misdemeanor conviction. For this person, housing support needs may be addressed with a short-term rent subsidy and employment services during the critical period following reentry. Conversely, a person with high housing support needs may have a disabling condition that prevents work, lack disability benefits, have co-occurring mental and substance use disorders, and have multiple felony convictions that prohibit access to many housing programs. For this person, a low-demand, supportive housing setting with long-term affordability and intensive services may be more appropriate. Some jurisdictions have implemented data-driven and need-driven housing initiatives to target the need for housing supports. These programs are designed to address local market needs by leveraging public resources to address specific issues, such as:

- Persons leaving prison with a high risk for reoffending;
- Frequent utilizers of services;
- Developing dedicated housing stock; and
- Mitigating policy barriers to housing access.

Examples of Data and Need Driven Justice Housing Options

Addressing Criminal Risk

Returning Home Ohio is a state reentry supportive housing initiative that targets people exiting state prison with moderate to high risk of recidivism and with significant barriers to stability, primarily serious mental health diagnoses. The project runs in four counties in Ohio and is funded by the Ohio Department of Corrections and Rehabilitative Services through reinvestment of correctional dollars. Community Supported Housing manages the initiative on behalf of the state by contracting with seven service providers who administer rental subsidies and provide residential support services. The Urban Institute conducted a preliminary evaluation which showed participants were 60 percent less likely to be reincarcerated, 40 percent less likely to be rearrested, and had stronger access to community services for mental health and substance use than a propensity-weighted matched comparison group (Fontaine et al., 2012).

Focusing on High Utilizers

MeckFUSE is a joint effort of Urban Ministry Center and Mecklenburg County Community Support Services Department. A data match between the homeless information system and the Mecklenburg County Sheriff's Office is used to identify and prioritize the most frequent cyclers of homelessness and the jail. Urban Ministries provides supportive housing with justice-informed intensive case management services in rented apartments in the private housing market. Funding for the program was provided through realigned reentry services funding to focus on higher need individuals that represented potential savings to public spending (Mecklenburg County Government, 2015).

Developing Dedicated Housing Stock

A number of developed supportive housing projects have leveraged capital from traditional affordable housing sources to create housing stock dedicated to justice-involved people. These projects are either single purpose buildings or supportive housing mixed with affordable housing for the broader community. In general, nonprofit agencies operate these programs with services funding from state and local agencies and philanthropic support. Examples include:

- **Castle Gardens II**, Fortune Society (Washington Heights, NY): 63 supportive and 50 affordable housing units collocated with 60 emergency shelter and long-term transitional beds.
- **K Street D'Addario Residence**, Providence House (Brooklyn, NY): 46 supportive housing units
- **St Andrew's Court**, St. Leonard's Ministries (Chicago, IL): 42 supportive housing units

Mitigating Policy Barriers

The New York City **Family Reunification Pilot Program** is an initiative run jointly by the New York City Housing Authority (NYCHA), Department of Homeless Services, Vera Institute for Justice, Community Supported Housing, and 12 nonprofit service providers. The initiative is a housing access strategy that provides relief from criminal justice exclusions to allow people to return to live with their families in public housing. Services are available to the individuals and their families leading up to and for six months following reunification. If the reunification is successful, the tenants' exclusions are permanently waived and they are added back to the lease. The family is protected from any negative consequences related to the reunification. Although in early stages, this is being looked at as a way to test lighter policy restrictions that could apply across NYCHA's more than half a million residents.

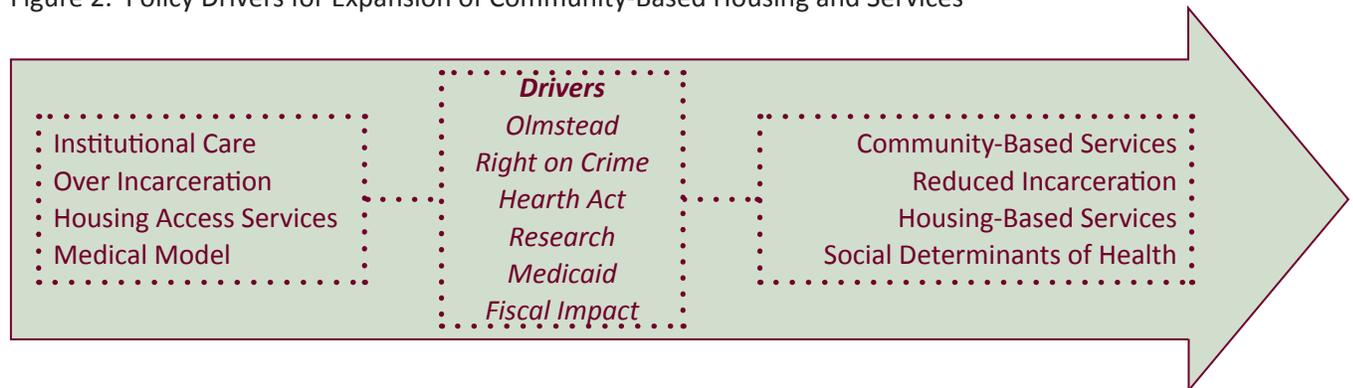
Implications

A growing body of evidence has demonstrated the effectiveness of specialized housing support initiatives for justice-involved persons with mental illness in achieving public health and public safety outcomes while reducing

costs. A set of policy drivers (see Figure 2), such as Olmstead mandates to serve people with mental illness in the most integrated settings, have opened the door for community alternatives to correctional mental health care. The State of Georgia is the first state that has had an Olmstead ruling that explicitly included criminal justice as one of the targeted settings for reform.

Pay for Success and other social impact bond ventures are gaining momentum and have the potential to leverage public and private funds in order to bring housing support interventions to scale while demonstrating a sufficient return on investment. The potential is certainly no greater than the scope of need given the volume of people with mental illness exiting jails and prisons each year.

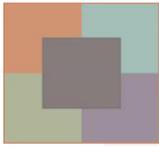
Figure 2. Policy Drivers for Expansion of Community-Based Housing and Services



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**Appendix 8:
Action Planning Chart
Template**



**SAMHSA'S
GAINS**
Center for
Behavioral Health and
Justice Transformation

Action Planning Matrix for Milwaukee County, WI

Priority Area 1:			
Objective	Action Step	Who	When